USAID/UKRAINE
HIV/AIDS STRATEGY
2003-2008

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ABBREVIATIONS AND ACRONYMS

AIDS	Acquired Immune Deficiency Syndrome
AIHA	American International Health Alliance
ARV	Anti-retroviral
BSS	Behavior Surveillance Survey
CSH	Child Survival and Health
DFID	Department for International Development
FSA	Freedom Support Act
GOU	Government of Ukraine
GFATM	Global Fund to Fight HIV/AIDS, Tuberculosis and Malaria
HIV	Human Immunodeficiency Virus
IDU	Injecting Drug User
IEC	Information, Education and Communication
IR	Intermediate Result
IRF	International Renaissance Foundation
MOH	Ministry of Health
MSF	Medecins Sans Frontieres
MSM	Men Who Have Sex With Men
NGO	Nongovernmental Organization
OHA	Office of HIV/AIDS
OVC	Orphans and Vulnerable Children
PLWHA	People Living With HIV/AIDS
PMTCT	Prevention of mother to child transmission of HIV
SME	Small and medium enterprises
STI	Sexually Transmitted Infection
TB	Tuberculosis
UISR	Ukraine Institute for Social Research
UN	United Nations
UNGASS	United Nations General Assembly Special Session
UNAIDS	Joint United Nations Programme on HIV/AIDS
USAID	United States Agency for International Development
USAID/W	United States Agency for International Development, Washington D.C.
USG	United States Government
VCT	Voluntary Counseling and Testing
WHO	World Health Organization

ACKNOWLEDGEMENTS

This strategy is based on two reports prepared by the Synergy Project, TvT Global Health and Development Strategies, a division of Social & Scientific Systems, Inc. for USAID/Ukraine. The first report was prepared by a team that included Joseph Amon, SYNERGY Consultant, Gerard Bowers, SYNERGY Consultant, Timothy Clary, USAID/E&E, Harriett Destler, USAID/G/OHA, and Thomas Tufte, SYNERGY Consultant. The second report was prepared by Joe Amon on the situation of HIV/AIDS in Ukraine. It was on the basis of this team's visit to Ukraine in November 2002 and their recommendations that USAID/Ukraine and USAID/Washington budgets for HIV/AIDS activities in Ukraine increased. This increase in funding and this Strategy reflect the sound and convincing approach they put forward for future programming. USAID/Ukraine extends our thanks to this team for their invaluable input.

This strategy incorporates recent developments in USG policy for HIV/AIDS, and it considers how best to strengthen USAID's contribution to the achievement of broader USG goals, for example strengthening the roles of faith-based organizations and creating links with anti-trafficking efforts. On the basis of a Chiefs of Mission meeting for US Ambassadors and USAID Mission Directors in the Europe and Eurasia region in February 2003, this strategy addresses the issue of stigma and discrimination; this was an area that was recognized as a priority by Ambassadors and USAID Mission Directors both in terms of need and the USG's comparative advantage in responding. This strategy also benefits from work carried out by other Ukrainian and international organizations as well as USAID/Russia all of whom graciously shared their previous experiences and lessons learned. The Mission would also like to take this opportunity to acknowledge the many efforts and contributions provided on previous drafts, and especially the work of the assessment team.

EXECUTIVE SUMMARY

In 2002, Ukraine was identified as one of 23 USAID priority HIV/AIDS countries on the basis of its escalating epidemic and potential for significant economic, political, and social impact. A priority HIV/AIDS country designation reflects the Agency, presidential and national priority given to addressing the worldwide pandemic. Early in his tenure, USAID Administrator Natsios identified combating the HIV/AIDS pandemic as "a top agency priority" and one of its greatest challenges.

Ukraine became a priority because, like its neighbor Russia, it is experiencing the fastest growing epidemic in the world. It appears that Ukraine will likely be part of what the U.S. National Intelligence Council has labeled the "next wave of HIV/AIDS,'' with "significant economic, social, political, and military implications." A model of the HIV epidemic developed in 2001 projected two potential scenarios of the future direction of the epidemic in Ukraine: an 'optimistic' scenario under which HIV prevalence increased to 2% of the adult population by 2010, and a 'pessimistic' model which projected more than 1,440,000 infected (4.9%) by 2010. By 2003, Ukraine has nearly reached the prevalence projected for 2010 under the 'optimistic' model.

Strategic Goals

The new strategy aims to reduce transmission of HIV through: 1) the adoption, promotion and facilitation of protective behaviors; 2) the strengthening of partners to plan, manage and evaluate HIV/AIDS programs; and 3) the mitigation of the impact of infection on those affected by reducing stigma and discrimination associated with HIV/AIDS. Additionally, as noted in the Bureau of Europe and Eurasia's "Incorporating Values Program", addressing the spread of HIV/AIDS and dealing with those infected and dying are intimately connected with choices and the values those choices reflect. Effective programs of HIV/AIDS prevention, care, and treatment must include an ethical dimension which infuses the educational, medical, and social components of the programs.

To achieve these goals, the strategy:

- Targets **concentrated sub-populations** (primarily injecting drug users) of the epidemic, with less intensive coverage of the general population;
- Focuses primarily on **prevention**, with smaller elements for care and support;
- Gives priority to **local level** programs, but still addresses policy issues at the national level;
- Promotes the active involvement of both the **public and private sectors**, especially at local levels.

Geographic Coverage

USAID resources will be focused in up to eight oblasts (Cherkasy, Crimea, Dnipropetrovsk, Donetsk, Kherson, Kyiv, Mykolayiv, Odessa) which have the country's highest prevalence of HIV, where a concentrated assistance program will be most likely to reach a critical number of high-risk population groups, where there is the potential for other funding sources to be accessed, and local level parties (NGOs, government bodies, civil society) are prepared to collaborate constructively in furtherance of strategic objectives. The actual number of high priority areas/cities selected for program activity will depend on the amount of USAID resources available to implement the strategy. If additional funding becomes available in one of the initially chosen oblasts to further

implement the USAID activities, additional oblasts may then be chosen for expansion under the program.

Objective and Intermediate Results of the Strategy

USAID/Ukraine in recognizing the potential serious effects of the HIV/AIDS epidemic on all aspects of life within the country has chosen to make HIV/AIDS a Special Objective (SPO). Implementation of this strategy will underpin the successful realization of SPO 3: *HIV Transmission Among High Risk Groups Reduced and Impact on Those Affected Lessened.* Three intermediate results (IRs) will be supported, including:

1. Strengthened delivery of HIV/AIDS information and services (65%).
2. Improved enabling environment (20%).
3. Reduced stigma and discrimination associated with HIV infection and AIDS (15%).

Intermediate Result 1: ***Strengthened Delivery of HIV/AIDS Information and Services (65%)*** seeks to increase coverage by information and services of a larger percentage of the most vulnerable, high-risk populations with effective, high-quality interventions. USAID support under this IR will strengthen the ability of local organizations to analyze, plan, and deliver effective information and services. Providers of information and services will also be supported to have a voice in national, regional and local decision making forums. Priority activities will include:

Prevention (60%):

- Information and services to prevent injecting drug transmission (65% of prevention efforts), sexual transmission (25% of prevention efforts) and mother-to-child transmission (10% of prevention efforts). At-risk youth will be targeted as a subcategory within the activities aimed at reducing injecting drug use and sexual transmission.

Care & Support for those Affected (22%):

- Expanded psycho-social support, self-help services.
- Family and community care of HIV positive children

Cross-Cutting Interventions (18%):

- Voluntary Counseling and Testing (VCT) services.

Intermediate Result 2: ***Improved Enabling Environment (20%)*** seeks to improve policy making, planning, management and evaluation so essential for the strategic and effective delivery of HIV/AIDS information and services. Activities in support of this IR will engage a range of partners, primarily at local levels, including local governments and leaders in the private sector and civil society. It will strengthen their capacity to plan, manage and evaluate interventions, and will include support for:

- Assessing, monitoring and evaluating the HIV/AIDS epidemic and available services.
- Strategic planning and management.
- Improving governmental policy and policy implementation.

Intermediate Result 3: ***Reduced stigma and discrimination associated with HIV infection and AIDS (15%),*** that adversely affects prevention, care and support efforts, will incorporate support for people living with HIV/AIDS with technical assistance, and financial and material support. Activities to be supported will aim to:

- Give voice to those affected by HIV/AIDS.
- Promote a supportive environment through communication strategies.
- Protect the rights of those affected by HIV/AIDS.

Addressing Gender Issues

Issues of gender are integral to this strategy. HIV transmission and infection to date has predominantly been among young males. That is not to say, though, that women have not also been affected, but rather the modes of transmission have differed between the sexes. Thus, some of the components under this strategy will by necessity be targeted at different audiences. Other activities will be targeted equally to both sexes.

Measuring Results for Intensive Focus Countries

Under the Expanded Response Intensive Focus Country Designation, USAID/Ukraine will be required to report on a number of HIV indicators. First, is the requirement to report annually on the HIV seroprevalence levels for Ukraine. The second requirement is to conduct behavior change surveys every three to five years. In addition, Intensive Focus Countries are required to report on indicators specific to the HIV strategies and programs they manage. These requirements correspond with standard, recommended guidelines for comprehensive program evaluation.

USAID/Ukraine's goal is to contribute to keeping HIV sero-prevalence less than 5% in the adult population in Ukraine by 2008. Additionally, USAID/Ukraine aims to slow the rate of transmission amongst those groups most at risk (IDUs and prostitutes) by one-half in the selected oblasts in which its programs are implemented. Selected indicators are summarized below, however, these indicators should be considered preliminary as USAID/Ukraine may refine them further in conjunction with USAID/W Office of HIV/AIDS (OHA).

Level	Key Indicators	Interval	Source*
SPO	HIV sero-prevalence for 15-24 year olds[1]	Annual	MOH
	% of HIV-infected infants born to HIV-infected mothers[1]	Annual	MOH
	HIV sero-prevalence among injecting drug users nationally[1] and in selected oblasts	2003, 2008	MOH & Rapid survey
	HIV sero-prevalence among prostitutes nationally[1] and in selected oblasts	2003, 2008	MOH & Rapid survey
IR	% condom use at last commercial sex among prostitutes nationally[1] and in selected oblasts	2003, 2008	SW BSS
	% drug injectors using condoms at last sex nationally[1] and in selected oblasts	2003, 2008	IDU BSS

[1] USAID/Ukraine, as an Intensive Focus Country, will report on several HIV/AIDS indicators that reflect the overall direction of the epidemic, and are required for broader Agency use (STATE 12958, 1/31/02). These national indicators are also "shared indicators", with other major donors requiring them. While these indicators are beyond the manageable interests of this Strategy, many of the activities supported will contribute to achieving progress that will be measured by these indicators that cover prevention, mother and child prevention, care & support and orphans & vulnerable children.

	% of USAID-supported NGOs and government organizations that collaborate with and provide support to other organizations not supported with USAID funding (in selected oblasts)	Annual	Self-assessment
	% of people expressing accepting attitudes toward PLWHA (in selected oblasts)	2003, 2008	BSS
	% coverage (by target population and site)	Annual	Rapid survey

* MOH=Ministry of Health; SW = sex worker; BSS=behavioral surveillance survey

In addition, all funded activities will have specific monitoring indicators to assess the implementation and quality of activities. These would be developed as part of work plans and agreements.

COUNTRY SITUATION
HIV and AIDS in Ukraine

Summary

More than 500,000 people in Ukraine are estimated to be infected with HIV. In 1995, HIV emerged as an explosive epidemic among injecting drug users (IDU). Since 1998, the epidemic has spread to all regions of the country, and it has been increasingly associated with heterosexual transmission. Between 1995 and 2001, the number of newly registered HIV cases due to heterosexual transmission increased from 300 cases/year to 1885; the number of cases due to vertical transmission from mothers to their newborn children increased from 9 cases/year to 914. While the majority of cases continue to be among men, and are due to injecting drug use, HIV prevalence among pregnant women has doubled between 1998 and 2001. Nearly a decade since the start of this explosive epidemic, NGO and government leaders estimate that current programs cover, at best, 15% of high risk populations.

The factors which led to this explosive growth include large numbers of injecting drug users (experts estimate that there are between 700-800,000 drug users throughout Ukraine, 80% of whom are believed to inject); low rates of condom use, especially among prostitutes and their clients (roughly 50% of prostitutes report consistent condom use with clients; one-fourth report having been forced to engage in unprotected sex by clients); and an large scale epidemic of syphilis beginning in the early 1990s (with the number of cases increasing from 3,000 to nearly 80,000 cases between 1990 and 1996).

Another factor which has facilitated the rapid spread of HIV in Ukraine is the high levels of stigma and discrimination faced by the marginalized populations which have been the focus of the epidemic. Drug users, prostitutes, and migrant populations within Ukraine have poor access to health information and services, and face discrimination from the specific groups of professionals whom could and should relate to risk populations: police officers, health workers, social workers, teachers, church leaders, in addition to decision makers, opinion leaders and media professionals.

A model of the HIV epidemic developed in 2001 projected two potential scenarios of the future direction of the epidemic in Ukraine: an 'optimistic' scenario under which HIV prevalence increased to 2% of the adult population by 2010, and a 'pessimistic' model which projected more than 1,440,000 infected (or 4.9% of the adult population) by 2010. By 2003, Ukraine has nearly reached the prevalence projected for 2010 under the 'optimistic' model.

Trends In HIV Seroprevalence

In 1987 the first HIV positive individual was diagnosed in Ukraine. By the end of 2001, 43,898 people have been officially registered as HIV+, and nearly 3,000 people have been diagnosed with AIDS. These figures are generally believed to represent only a small fraction of the actual number of infections in Ukraine. Ministry of Health officials and international experts estimate that by the end of 2002, more than 500,000 people from every part of Ukraine are infected, representing more than 1% of the total Ukrainian population or nearly 2% of the adult (15-49) population. Ukrainian health officials identify three distinct phases of the HIV epidemic to date:

Phase I (1987-1994)
From 1987 to 1994, fewer than 50 cases of HIV per year were registered in Ukraine. Cases detected were primarily found among foreign students. All registered cases were identified as being due to sexual transmission.

Phase II (1995-1997)
In 1995, a sudden new epidemic emerged among injecting drug users (IDUs) in the southern and eastern regions of Ukraine. The number of reported HIV infections increased rapidly from less than 50 per year to more than 5,000 per year by 1996. Research by Nabatov and others (2002), examining the phylogeny of HIV strains present in southern Ukraine at the start of the epidemic, found evidence suggesting two separate HIV strains were introduced into IDU communities: type HIV-1 IDU-A in Odessa and IDU-B in Nikolaev. HIV type IDU-A appears to have spread much more rapidly throughout the former Soviet Union, while IDU-B is much less commonly seen.

Phase III (1998-2002)
By 1998 multiple epidemics were converging in Ukraine, with increasing cases of heterosexual transmission (from 300 cases/year in 1995 to 1885/year in 2001); on-going transmission among IDUs; increasing vertical transmission (from 9 per year in 1995 to 914 in 2001); and growing prevalence among pregnant women (from 0.12% to 0.22% between 1998 and 2001). Between 1997 and 2001, data from newly registered HIV cases (Ukrainian AIDS Center, 2002) show a sharp decrease in the proportion of IDU related HIV transmission, and significant increases in both heterosexual and perinatal transmission (see figure 1).

Figure 1: Proportion of registered HIV cases, 1997 and 2001

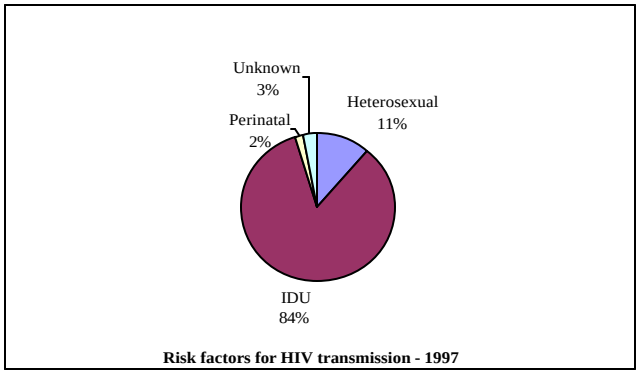


Figure 2: Estimated proportion of HIV cases by sex, 2001

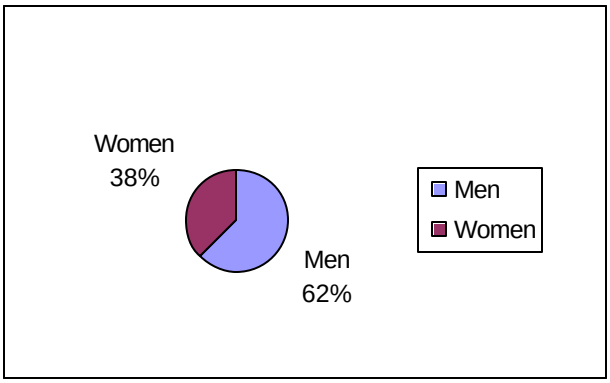
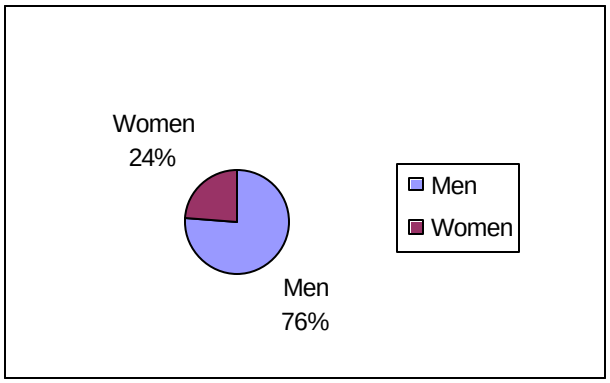


Figure 3: Estimated proportion of AIDS cases by sex, 2001

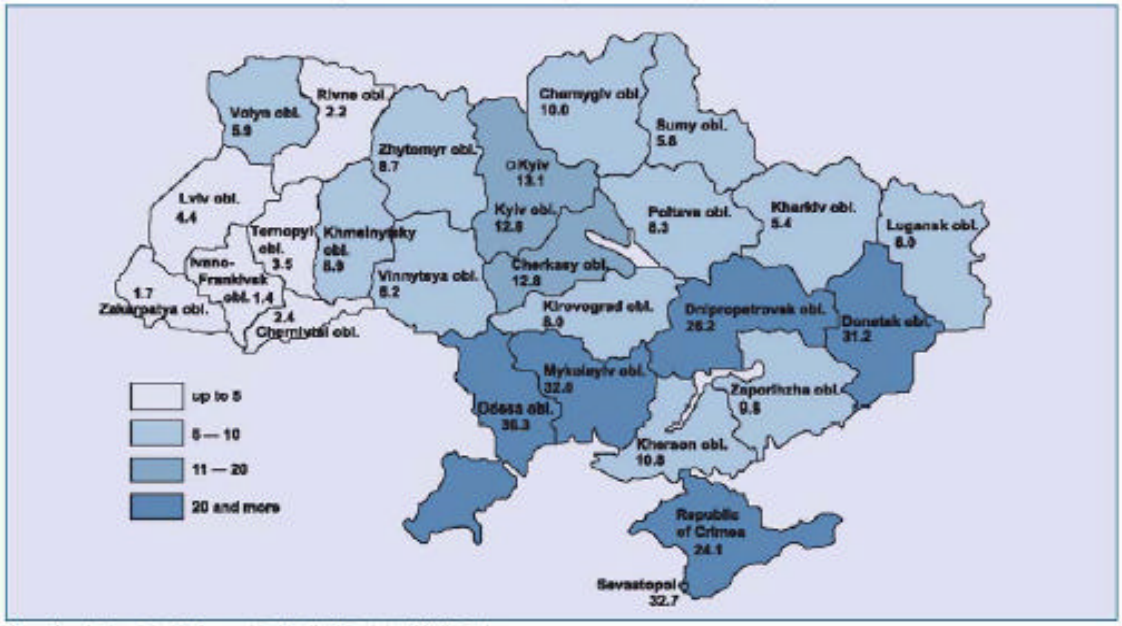


Certain biases in the system of officially registered HIV positive case reporting must be recognized in interpreting this information however. For example, official reporting is estimated to include no more than 10% of new cases, and a greater percentage of IDUs and other marginalized populations, with limited access to the health care sector, are believed to be undercounted.

In this phase of the HIV epidemic, HIV positive individuals are now seen in each of the nation's 25 oblasts (see figure 2). The highest prevalence is in the south and east, with Odessa, Mykolayiv, Dnipropetrovsk and Donetsk oblasts forming a continuous belt of high prevalence, and the Republic of Crimea and Sevastopol reporting similarly high rates. Rates in these regions are roughly three times higher than the rest of the country. The next highest zone (with rates 50-100% higher than the rest of the country) is in the central heart of the country, Kiev (city and oblast) and Cherkasy.

MAP 1

Figure 2
Number of Oficially Registered HIV-positive People in Ukraine, by Region, per 100 000 Population (2001)



According to the data kindly provided by the Ukrainian AIDS Centre

Truly understanding the nature of the epidemic in this last phase however is complicated by an inadequate national surveillance system, principally focused upon blood donors and pregnant women. Although aggregated national data of registered new cases of HIV show an apparent plateau from 1997-2000, disaggregated data and focused cross-sectional studies show increasing, high prevalence in specific, marginalized populations which are not included in national surveillance data (Amon, 2003). For example, Kobyshcha (1999) reported that only 5% of drug addicts were covered by the current system of HIV surveillance. Results of HIV prevalence surveys in populations at high risk have found:

- 18% - 64% of IDUs surveyed in six Ukrainian cities in 1999 and 2000 were HIV positive.

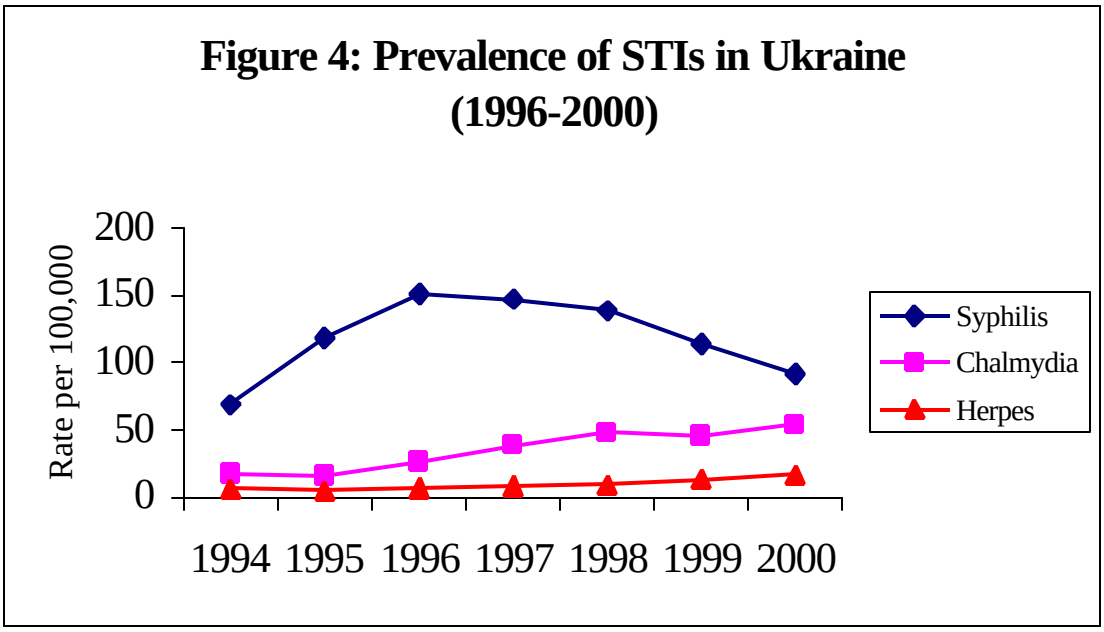
- Among prostitutes, a 1999 survey in Donetsk found an HIV prevalence of 13% and a prevalence of syphilis of 37% .

- The Ministry of Health found a 35% overall increase in the prevalence of HIV among patients with sexually transmitted infections (STIs) between 1998 and 2000 (MOH, 2001).

Trends in STI Prevalence

STIs, particularly ulcerative STIs such as syphilis, accelerate the progress of HIV epidemics by increasing the risk of HIV transmission. Countries which have seen rapid escalation in their HIV epidemics often have underlying STI epidemics, and poor availability and access to quality STI treatment.

In Ukraine, an explosive syphilis epidemic beginning in the early 1990s appears to have both foretold and facilitated the subsequent rise of HIV. National figures show that the reported number of syphilis cases dramatically increased between 1990 and 1996 from 3,000 to nearly 80,000 cases As with the surveillance data on HIV, the validity and reliability of STI data is uncertain. Some Ukrainian experts have identified an increase in private sector treatment, and/or decreased access to treatment among marginal populations as possible alternative explanations for the apparent decreased numbers of syphilis cases reported after 1996.



(Source: G.I. Mavrov and G.M. Bondarenk, 2002)

Tuberculosis and HIV

Economic and social factors such as poverty, dwindling resources for public health, substance abuse, especially alcohol and injecting drug use have contributed to the substantial increase in tuberculosis (TB) cases in Ukraine during the last decade. These same factors have also contributed to the spread of HIV infection. In 2001 an estimated 41,225 people in Ukraine were infected with tuberculosis giving a rate of 84 per 100,000. In 2002, a confirmed 36,471 people have been notified with tuberculosis giving a rate of 76 per 100,000. USAID/Ukraine's program for tuberculosis to date has mainly focused on the piloting of the Directly Observed Treatment Strategy (DOTS) in Donetsk oblast. It is hoped that by showing the effectiveness of DOTS in Donetsk, that further acceptance of the program will be forthcoming from the GoU, leading to acceptance of the

internationally recognized, cost-effective approaches to TB control. In general, though, DOTS implementation has been protracted and progress has been slow.

There may also be a substantial overlap between populations with active TB disease, those infected with TB and those at risk for HIV infection, leading to a potential increase in the number of co-infected individuals. The yearly risk of developing active TB for people co-infected with HIV is about 10%, compared with a lifetime risk of 10% for HIV-negative individuals. If the spread of HIV is not prevented, co-infection will accelerate the resurgence of TB. The potential for massive TB spread in HIV-infected individuals in settings such as prisons, in which the rates of TB and multi-drug resistant TB (MDR-TB) are the highest, is especially alarming. The system in Ukraine for diagnosing and treating tuberculosis is like the system for HIV/AIDS in that it is highly vertical. Little active interaction has taken place to date between these two systems, although in some oblasts such as Donetsk there is a growing recognition that collaborative efforts are needed.

HIV-Related Risk Behaviors

Two aspects of risk behavior greatly influence the degree of susceptibility Ukraine has to an expanding HIV/AIDS epidemic:

1. the *numbers* of individuals engaged in such risk behaviors as injecting drug use and transactional sex; and

2. the *level of unprotected behaviors* of those populations. Authoritative information on either of these topics is largely unavailable. However, a small number of studies do begin to provide some estimates of the role and magnitude of these factors.

Unsafe Injecting Practices

Government and academic experts estimate that there are between 700-800,000 drug users throughout Ukraine, 80% of whom are believed to inject. The majority (roughly 75-85%) of injecting drug users are men. However, a more detailed understanding of the sub-cultures of drug users in different regions of the country, their drug and sexual behaviors, mobility, knowledge of HIV, and prevalence is unavailable. Interviews with NGO representatives, outreach workers and researchers provide an anecdotal picture of a diverse, and isolated, drug using population.

At the lowest socio-economic level are 'hard core' users, purchasing, and often using, drugs in open air markets, enclosed stairwells, and abandoned buildings. This population is generally older, has used drugs for a longer period of time, and has significant health problems (hepatitis, STIs, abscesses, etc.) in addition to high levels of HIV infection. Individuals in this group are usually unemployed, or (among women) may engage in prostitution.

The second general strata of drug users are those in small 'hidden' cells: these drug users are also often older and have frequently used drugs for a considerable period of time, but do not purchase or use drugs through open-air markets. These individuals have a relatively small closed network of fellow drug users with whom they share drugs, and they often use drugs alone or with a small number of people at their home.

In the third strata, are those who use drugs less frequently, including those of a higher economic status, students, and laborers. This group is probably the least understood, and consequently the least reached by current interventions, in part because of the apparent lack of risk felt by occasional

drug users. A study of university students revealed they do not perceive themselves as having a drug problem, or at risk of contracting HIV. Their knowledge of HIV is relatively low due to generally limited awareness among youth. University students are an unexplored and probably large community of IDUs and risky sexual behaviour not reached by current non-governmental services.

Common to all of these groups are several characteristics which make it difficult to promote risk reduction measures:

- drug users are reluctant to seek medical aid for fear of being registered, which leads to compulsory treatment or possibly criminal proceeding (and can lead to loss of job, drivers license, and other negative consequences);
- lack of a sense of risk; and
- a feeling of fatalism and lack of empowerment.

While a few studies have been conducted of IDU knowledge, attitude and behaviors, these studies often reach a small segment of the overall IDU population, which may not be representative. The simple fact that NGO and government leaders estimate that current programs cover, at best, 15% of the IDU population, clearly indicates that a significant level of risk behaviors is occurring unchecked.

A detailed qualitative/semi-quantitative study of IDU behaviors in Ukraine was conducted by the Ukrainian Institute of Social Research in conjunction with the World Health Organization (WHO), in the city of Kharkiv. This study found widespread injecting risk behavior, notably shared use of syringes and needles, and purchase of pre-made drugs. An earlier quantitative study conducted by the NGO '*Chervona Strichka*' in 1999 in Kharkiv found similar high rates of risk: 94% of IDUs bought pre-made drugs, 48% drew drugs from a shared vessel, 68% loaded their drugs from others' syringes ('mostly' or 'usually'), and a minority (38%) reported not sharing syringes.

Two smaller studies conducted with IDUs in Odessa and Kiev are cited in a DFID/British Council report entitled "Cost-effectiveness analysis: Aiding decision-making in HIV prevention in the Ukraine". These studies found significant reductions in risky needle injection behavior after two years of intervention, but still considerable overall rates of risk (for example, in Odessa, only 36% of IDUs reported not sharing syringes).

Trends in the overall use of drugs in Ukraine are unreliable. There is some evidence, however, that drug use may be increasing among youth. According to a survey in Kharkiv, for example, the age of IDUs officially registered or seeking addiction treatment is decreasing, and the percentage of youth ever offered drugs increased from 42% in 1995 to 62% in 1999.

Risky Sexual Behaviors

High rates of prostitution and unprotected sex are reflected in the high rates of syphilis and other STIs mentioned previously. Condom use among prostitute and IDU populations is low, and inconsistent. Among youth in general, condom use also appears to be relatively low. Relatively little is known about their numbers of sexual partners. One encouraging note, however, is the relatively late age of first sexual experience as discussed below (compared to other countries with high HIV prevalence).

Youth

In 1999 USAID supported a national reproductive health survey conducted among 9,000 females aged 15-44 years. Results from this study found that the median age at first sexual intercourse was 18.4 years. The proportion of 15-17 year-olds reporting that they had ever had intercourse was relatively low, 18%. These results are similar to that found in a study conducted in 2000 of both male and female youth, which found the percent of youth sexually experienced increasing from 30% at age 16 to 70% at age 18. The same study found 21% of youth reported two or more partners in the last 3 months. Little credible information is available about the level of condom use among youth, although anecdotal reports indicate low levels of consistent use. The 1999 Ukraine Reproductive Health Survey found that only 27% of women reported condom use at the time of their first sexual experience.

Prostitutes

With the independence of Ukraine in 1991 there was a reported increase in the number of prostitutes and clients. Prostitutes represent a wide age range (from children as young as 10 to persons over 40), and a wide range of education and professional attainment, including men and women with university degrees and full-time jobs. The MOH/UNAIDS "HIV/AIDS in Ukraine: Situation Analysis" (March-May 2000) reports that prostitutes include sales representatives, students, engineers, teachers, and unemployed. Several strata of prostitutes can be identified, including: elite; call-girls and boys; those who work in saunas, cafeterias, hotels and discos; those who work on the streets and squares; those who work in trains; highway prostitutes; and railway station prostitutes. The report also highlights the frequent introduction and turn-over of new prostitutes. For example, one-fourth of female prostitutes surveyed in Odessa stated that they had been working for less than six months.

Both alcohol and drug use are common among prostitutes. Among prostitutes surveyed in 11 cities throughout Ukraine, 40% report drinking frequently, and the percentage using injecting drugs covered a wide range from 3% to 50%. Injecting drug use was highly negatively correlated with level of education. Only 1% of female prostitutes who had completed or had at least some higher education reported injecting drug use. However, roughly 30% of those with only a secondary or lower education reported injecting drug use.

Roughly one-half of prostitutes reported always using condoms with clients. Alarmingly, rates of condom use appear to decline the longer a woman works as a prostitute. One study showed rates declining from 55% among female prostitutes working for less than 6 months to 46% among those working greater than 3 years. Just under one-half (47%) reported unsafe sex with regular partners, while 30% reported regular sexual contact with individuals who used injecting drugs. On average, female prostitutes reported 10-20 clients per week.

Women engaged in prostitution reported a high degree of vulnerability and exposure to violence and exploitation. One-fourth of female prostitutes reported having been forced to engage in unprotected sex by clients. Fifteen percent reported that they had agreed to engage in unprotected sex when clients offered extra pay. In a pre/post study of female prostitutes in Odessa, conducted in 1997 and 1999, the percentage of prostitutes reporting always using condoms actually declined (from 49% to 40%), although those reporting never using condoms also declined, with a majority (55%) reporting inconsistent condom use, perhaps from a lack of awareness of the risk of HIV or due to an inability to insist upon condom use with clients.

Men Having Sex with Men (MSM)

Infection levels among MSM in Ukraine have been calculated starting in1987. The data provided by the Ukrainian AIDS Prevention Center at the Ministry of Health shows that the number of HIV infections transmitted through homosexual contacts is very low as compared to other modes of transmission. The total number of cases in 2001 was 41, which was approximately .09% of the overall number of registered HIV cases. No information is available on the risk behaviors, STI or HIV prevalence of men who have sex with men. Although NGOs in Odessa and Lviv reported having attempted some outreach efforts to individuals in these communities, the general impression was that discrimination was so strong against this population that intervention programs would be difficult. Nonetheless, male escort services are openly advertised in Kiev, and a greater understanding of this population is urgently needed.

Bridge Populations

Little is known as well about potential 'bridge' populations, which facilitate the spread of HIV from such known high risk groups as IDUs and prostitutes, into the broader population. More research is needed on the clients of prostitutes, on young soldiers and sailors, and on workers in the transport sector (such as truckers operating between the Odessa port and other regions of the country or neighboring countries).

Socio-Economic and Contextual Factors Influencing the Epidemic

Economic re-structuring in the 1990s heavily impacted eastern regions of the country including Dnipropetrovsk, Donetsk, Zaporizhia, Lugansk, and Kharkiv oblasts. Alcohol and drug abuse in these regions, as well as throughout Ukraine, is a particularly entrenched social problem. Widespread home production of alcohol (with associated high potency and low cost) increases the risk of alcohol abuse. Among youth, the extent to which drugs and alcohol are used is unclear, but some reports indicate that both are concentrated in a subset of the general youth population, with the overall average intake of alcohol modest, and equal to 1-2 drinks/month.

Economic restructuring has also led to high rates of migration in Ukraine, particularly among youth. Between 1994 and 2000, Ukraine lost 90,000 people a year. According to the National Institute of Ukrainian - Russian relations, there are 300,000 Ukrainian migrant workers in Russia alone. The number of individuals working as small traders (*chelnoki*) traveling to/from neighboring countries, and possibly engaging in high risk behaviors, is unknown. Migration is also seen among prostitutes, who often move to larger cities to increase their potential income, and ensure anonymity. A study of prostitutes in 11 cities in Ukraine found that local women formed the majority (63% to 78%) of prostitutes in Kherson, Kharkiv, Odessa and Dniepropetrovsk, while migrants formed the majority (60% to 65%) of prostitutes in Kiev, Simferopil, and Mykolaiv. Unsurprisingly, poverty was the cause most likely to be cited by prostitutes as a cause for their employment, and prostitution was the main source of income for most (77%) of the prostitutes surveyed.

Gender inequality is also an important issue contributing to an environment conducive to explosive growth of HIV. Women face a higher level of unemployment, lower wages, and little representation in government and municipal services. However, the full extent and consequences of sexual harassment and violence against women in Ukraine is unknown.

The marginalized populations which have been the focus of the epidemic face heavy discrimination not only from the population as a whole, but from the very professionals and service providers who could assist populations at risk: police officers, health workers, social workers, teachers, and church leaders. The same can be said for decision makers, opinion leaders and media professionals who

influence legal frameworks and public attitudes that affect the lives of these populations. Mandatory registration fuels the stigma and discrimination that leads to social isolation, the loss of jobs and drivers licenses, and possibly criminal proceedings. Numerous accounts from both NGOs working with risk populations, from people living with HIV/AIDS (PLWHA), injecting drug users (IDUs) and prostitutes indicate that discrimination and stigmatization is widespread. The result is that high risk populations are very hard to reach with information and services.

The general lack of knowledge about HIV and AIDS in the local community reinforces stigma and discrimination. Risk populations suffer a multitude of negative consequences from being an IDU or prostitute, or from having disclosed their HIV-positive status. IDUs feel highly stigmatized by negative attitudes towards them, and even more burdened if they are also HIV positive and a prostitute. They experience rejection from the community they live in. Consequently, IDUs are not motivated to know their HIV status, and if they know it and are HIV positive, they tend to avoid disclosing their status. Ultimately, the consequence of discrimination and stigmatization is their withdrawal into isolated IDU communities that are difficult to access and help.

The situation for prostitutes is similar. A new criminal code, effective since September 1, 2001, criminalized prostitution. This new law has increased prostitutes' fear of contact with public authorities, other service providers, and the police. Furthermore, the general attitude towards prostitution is negative. Seventy-five percent of Ukrainians believe prostitution can never be justified. These unfavorable conditions make outreach work difficult and emphasize the need to establish clear partnerships with relevant public authorities. Partnerships are needed to secure rights to legal protection and service provision for those at risk. Several NGOs working with these target populations have begun to establish such partnerships.

Men who have sex with men (MSM) is another group about which little is known. A few NGOs, such as *All Together* and *Salus*, work with them, but it is a difficult risk population to reach. A deeper analysis of their behavior and practices is required to develop strategies to reach and work with MSMs. Data on the relatively low spread of HIV among MSMs should be interpreted with caution as homosexuality was illegal and punishable until 1991. Low rates of reporting are to be expected.

Another factor contributing to the spread of the epidemic is human trafficking. As noted at the Budapest Conference on Trafficking and Health (March 2003), Ukrainian women and children are one of the groups most frequently trafficked for sex and exploitation in the region. Yet, relatively little is known about human trafficking and its consequences for Ukraine. Results from one shelter in Kyiv in August 2002 found that up to 66% of returning victims had a sexually transmitted infection, and 68% were HIV positive.

Findings from studies conducted by the Ukrainian Institute for Social Research (UISR) and the International Renaissance Foundation (IRF) found a range of shortcomings in the media which reinforced stigma, including: de-personalized and superficial coverage of IDUs (largely jokes about users and drug stories of film and pop stars) and lack of authoritative information from experts in the field of drug addiction and prevention. Most of the publications furthermore showed unsympathetic attitudes to the problems of IDUs, prostitutes and HIV.

Future Directions of the HIV/AIDS Epidemic in Ukraine

According to UNAIDS, Ukraine rivals Russia for the distinction of being the country with the most rapidly growing HIV/AIDS infection rate in the world. Like Russia, Ukraine has a declining and

aging population, inadequate health and other social services, declining life expectancy, and rising rates of tuberculosis infection and substance abuse. There is little reason to believe the consequences will be less in Ukraine than in Russia, where a recent National Intelligence Council assessment found the rise of HIV/AIDS will "exacerbate population decline and severe health problems already plaguing the country, creating even greater difficulties for Russia to rebound economically…A contracting workforce and exploding health care costs will be serious counterweights to economic growth." A recent World Bank study projected an annual cut in economic growth in Russia by half a percentage point by 2010 and a full percentage point by 2020 due to HIV/AIDS.

In Ukraine, projections of the future impact of the HIV/AIDS epidemic have been made using both the EPIMODEL software program (CDC) to estimate the present number of individuals who are HIV+, and the SPECTRUM model (Futures Group International) to estimate future numbers. While any projections are necessarily limited by the inadequate data currently available and assumptions inherent within the models, the projections do allow a general sense of the potential course of the epidemic over the short term, based upon recognized epidemiologic factors.

The SPECTRUM model developed two scenarios: an 'optimistic' scenario which started with an estimate of 370,000 individuals infected with HIV (1.2% of the adult population) in 2002 and increased to 510,000 (1.7%) by 2007 and 580,000 (2%) by 2010. The pessimistic model started with an assumption of 530,000 individuals infected in 2002 (1.7%), 1,130,000 infected (3.7%) in 2007, and 1,440,000 infected (4.9%) in 2010. Without considering the impact of the HIV/AIDS epidemic, life expectancy in Ukraine would be expected to increase two years for men and one year for women between 2002 and 2010. By contrast, including HIV/AIDS mortality reduces life expectancy in 2010 by 2-5 years (under 'optimistic' and 'pessimistic' scenarios). Reduced life expectancy and decreased fertility due to HIV infection together will result in a decreased overall Ukrainian population of over two million people (from 47.28 million in 2005 to 45 million in 2010). The model also projects lost productivity and significant declines in gross domestic product, and social support (welfare and pension) in the future.

USAID/UKRAINE HIV/AIDS STRATEGY

Responses to the Epidemic and Lessons Learnt

In 1997 and 1999, USAID assessments of the HIV/AIDS situation showed that local agencies had marginal resources and were overwhelmed with the challenges posed by an epidemic driven by injecting drug use. Observations in these assessments noted a lack of knowledge about HIV among high-risk populations; lack of coordination among non-government organizations (NGOs) and government agencies; high levels of stigma; and lack of clinical and counseling centers for HIV-positive patients. Subsequent assessments done by other organizations, such as UNAIDS and Monitoring the AIDS Pandemic (MAP), reached similar conclusions. Five years later many of these observations are still valid. Details of "Responses to HIV/AIDS in Ukraine and Lessons Learnt" to date are summarized in Annex I.

Ukraine as a Priority Country for USAID Assistance

In 2002, Ukraine was identified as one of 23 USAID priority HIV/AIDS countries on the basis of its escalating epidemic and potential for significant economic, political, and social impact. A priority HIV/AIDS country designation reflects the Agency, presidential and national priority given to addressing the worldwide pandemic. Early in his tenure, USAID Administrator Natsios identified combating the HIV/AIDS pandemic as "a top agency priority" and one of its greatest challenges.

In the spring of 2002, the Administrator approved a stepped-up, more focused approach to combating HIV/AIDS with a new operations plan, entitled "War on AIDS." This plan mandated stand-alone HIV/AIDS strategies and more extensive reporting for priority countries, and the number of priority countries was increased from 19 to 23. Ukraine was one of four new countries added to USAID's priority list of intensive-focus countries. Ukraine became a priority because, like its neighbor Russia, it is experiencing the fastest growing epidemic in the world. It appears that Ukraine will likely be part of what the U.S. National Intelligence Council has labeled the "next wave of HIV/AIDS,'' with "significant economic, social, political, and military implications."

USAID/Ukraine sponsored an assessment of the country situation in November 2002. The assessment showed that, despite support from a number of international partners and the government (including USAID's efforts to strengthen prevention, care and support through 25 NGOs in 20 regions), local governmental, NGOs and civil society organizations continue to lack the resources to address the challenges posed by an epidemic driven by injecting drug use and increasing sexual transmission. A decade after HIV was introduced into Ukrainian society, the assessment team concluded that prevention efforts have only reached some 10-15% of high risk groups. They recommended that USAID adopt a focused approach, both programmatically and geographically. They further encouraged USAID to demonstrate the strategic value of a comprehensive but targeted response, and to encourage other partners to adopt a similar approach.

In February 2003, the U.S. Ambassador to Ukraine hosted a Europe and Eurasia regional Chiefs of Mission conference focused on HIV/AIDS in the region. That conference concluded that "low prevalence is not low priority" and that it was urgent to intervene now with increased resources and control efforts. This strategy contributes toward the goal of keeping Ukraine a "low prevalence" country. While most experts agree that the 1% threshold has been crossed already, the goal is to keep national seroprevalence under 5% through the end of FY 2008.

Strategic Approach

This HIV/AIDS Strategy will provide the strategic framework for USAID/Ukraine support through 2008. The estimated total contribution will be US$17.5 million, and incorporates continued assistance from USAID/W through the Child Survival and Health account. The new strategy aims to reduce transmission of HIV through: 1) the adoption, promotion and facilitation of protective behaviors; 2) the strengthening of partners to plan, manage and evaluate HIV/AIDS programs; and 3) the mitigation of the impact of infection on those affected by reducing stigma and discrimination associated with HIV/AIDS. Additionally, as noted in the Bureau of Europe and Eurasia's "Incorporating Values Program", addressing the spread of HIV/AIDS and dealing with those infected and dying are intimately connected with choices and the values those choices reflect. Effective programs of HIV/AIDS prevention, care, and treatment must include an ethical dimension which infuses the educational, medical, and social components of the programs.

To achieve these aims, the strategy:

- Targets **concentrated sub-populations** (primarily injecting drug users) of the epidemic, with less intensive coverage of the general population;
- Focuses primarily on **prevention**, with smaller elements for care and support;
- Gives priority to **local level** programs, but still addresses policy issues at the national level;
- Promotes the active involvement of both the **public and private sectors**, especially at local levels.

This approach will foster a coordinated, strategic, public-private effort to scale up and create a critical mass of quality HIV/AIDS services in a limited number of high priority oblasts (see ***Geographic Coverage*** page 23 for selection criteria). The focus on a targeted approach will be essential to bringing about significant, measurable behavior change among vulnerable populations and to slowing down the epidemic. Current pilot efforts by NGOs and emerging public-private partnerships in HIV/AIDS prevention and care are too modest and fragmented to significantly impact the pandemic. For example, NGOs working with injecting drug users (IDUs) estimate they are reaching only 2 to 15 percent of the target population.

Even with modest resources, USAID (and the U.S. government) will continue to be actively engaged in policy dialogue and programming for HIV/AIDS in Ukraine. The former becomes particularly important as significant funds are made available through the Global Fund Against AIDS, TB and Malaria (GFATM). The three main intermediate results proposed under this Strategy supplement and complement activities planned by other organizations, including the GFATM. The $92 million dollars expected from the Global Fund is mainly aimed at care, support, and treatment (67 percent), with lesser portions devoted to prevention activities, high-risk populations, and monitoring and evaluation. The U.S. government is heavily vested in the success of the GFATM, which acts principally as a financing rather than a technical agent. Members of the U.S. team in the Ukraine will continue to use all the tools at their disposal in policy dialogue, communications with Washington, technical assistance, and donor coordination to ensure that these funds, as well as any other donor resources, are appropriately and transparently used to address the HIV/AIDS problem in Ukraine.

Strategic Objective and Results

USAID/Ukraine in recognizing the potential serious effects of the HIV/AIDS epidemic on all aspects of life within the country has chosen to make HIV/AIDS a Special Objective (SPO). Implementation of this strategy will underpin the successful realization of SPO 3: *HIV Transmission Among High Risk Groups Reduced and Impact on Those Affected Lessened.* Shown in Annex III is the SPO with its associated Intermediate Results (IRs). The focus on changed behaviors and systems development reflects achievements expected under this Mission HIV/AIDS Strategy and builds on previous efforts to create a strong response to HIV/AIDS by civil society and non-government organizations (NGOs) and to establish a supportive national policy. The three IRs to be supported include:

1. Strengthened Delivery of HIV/AIDS Information and Services (65%).
2. Improved Enabling Environment (20%).
3. Reduced Stigma and Discrimination Associated with HIV Infection and AIDS (15%).

While the USAID/Ukraine Office of Health and Social Transition will continue to provide the primary technical leadership for this program, a broader Mission effort, with strong leadership from senior management and the Embassy, will support implementation of the overall strategy. For example, on-going activities and planned activities under Strategic Objective (SO) 4, such as the regional training for mayors and other local leaders and strengthening the law and its application at the local level, will help improve local planning and service delivery, as well as secure the trust of vulnerable populations and protection of their rights. Other SO2, SO3, and SO4 activities with small and medium enterprises, cooperatives, and agricultural institutions and rural clubs will provide important, low- or no-cost ways to increase knowledge and understanding of HIV/AIDS and reduce stigma. Previously, there were a number of synergies with other programs.

The democracy and governance components of the Mission's Strategy are important to highlight because they play a role in the Mission's *de facto* multi-sectoral response to the HIV/AIDS epidemic. In addition, the Ukraine Reform Education Program (UREP) has been working with the media, training journalists and building capacity of the NGO sector to place HIV/AIDS issues on the public agenda. In 2002, UREP began working on HIV/AIDS with *Internews Ukraine*. *Internews* has considerable experience in raising the quality of media materials, in producing, facilitating and promoting the distribution of programs to local media. Since 1996, *Internews* has been involved in many HIV/AIDS-related media activities through television, radio and journalists. Contrary to most local NGOs, *Internews* has been successful in accessing free airtime on radio and television. UREP is currently exploring a new medium, not seen before in Ukraine: the radio soap opera. Internationally, it has a proven track record as a means of raising awareness among broader target populations. Lastly, the USAID anti-trafficking program is also working with populations at risk, namely women, youth and children who are either vulnerable to trafficking or are victims. This Strategy provides opportunities to reach these groups by strengthening the links between those organizations responding to human trafficking and those working to address HIV/AIDS.The Mission and its partners will use their full analytic resources to better understand the impact of HIV/AIDS on key sectors and programs and the steps needed to mitigate suffering and civil unrest.

Geographic Coverage

USAID resources will be focused in up to eight oblasts (Cherkasy, Crimea, Dnipropetrovsk, Donetsk, Kherson, Kyiv, Mykolayiv, Odessa) which have the country's highest prevalence of HIV, where a concentrated assistance program will be most likely to reach a critical number of high-risk population groups, and local level parties (NGOs, government bodies, civil society) are prepared to collaborate constructively in furtherance of strategic objectives. The actual number of high priority areas/cities selected for program activity will depend on the amount of USAID resources available to implement the strategy.

USG Policy Framework

USAID/Ukraine will implement this HIV/AIDS Strategy in accordance with applicable laws and administration and agency policies. Activities designed to stem the transmission of HIV/AIDS among high risk groups, such as prostitutes and injecting drug users, are clearly needed in light of all the evidence. Such activities and related communications must be managed sensitively. Existing USAID policy, set forth in the Agency's *FY 2003 Guidance on the Definition and Use of the Child Survival and Health Programs Fund*, provides guidance on prevention programs for injecting drug users and the use of funds for population activities. In addition, State cable 267675 (Dec 2002) specifies that organizations advocating prostitution as an employment choice, or which advocate or support the legalization of prostitution, are not appropriate partners in USAID anti-trafficking activities, at any level. These laws and policies are summarized in Annex IV.

RESULTS OF USAID/UKRAINE'S HIV/AIDS STRATEGY

In dealing with challenges as big and complex as the HIV/AIDS epidemic in Ukraine, USAID will support three IRs that are mutually reinforcing and interlinked. With modest financial resources, USAID seeks to complement and support efforts by the GOU, Ukrainian grantees of the Global Fund Against AIDS, TB and Malaria, the World Bank and other donor funded HIV/AIDS programs. USAID/Ukraine has selected three IRs under its strategy that aim to:

1. Strengthen the Delivery of HIV/AIDS Information and Services (65%).
2. Improved Enabling Environment (20%).
3. Reduce Stigma and Discrimination Associated with HIV Infection and AIDS (15%).

IR 1: Strengthened Delivery of HIV/AIDS Information and Services (65%)

Intermediate Result 1: ***Strengthening the Delivery of HIV/AIDS Information and Services (65%).*** One goal of the new strategy is to increase coverage by information and services of a larger percentage of the most vulnerable, high-risk populations with effective, high-quality interventions. These services lead to increased knowledge, reduced risk behaviors, and decreased HIV transmission. USAID support under this IR will strengthen the ability of local organizations to analyze, plan, and deliver effective information and services. The delivery of these services will enable the adoption of protective behaviors and reduce the risk of infection for marginalized and vulnerable populations. This aspect of the USAID strategy will emphasize strengthening both public and non-governmental providers of information and services, but more importantly, it will encourage these organizations to work collaboratively in addressing the escalating burden of HIV infection. The activity will be implemented in up to eight oblasts (depending on levels of funding) of the highest HIV prevalence.

To achieve these goals, a range of non-governmental and civil society organizations will be supported through financial grants and technical assistance to provide information and services for prevention, care and support of HIV infection. Close cooperation between local authorities, medical establishments, educational institutions, law enforcement agencies, the media and other community groups and organizations is required to ensure efficient prevention approaches and build a sustainable approach.

Priority activities will include:

<u>Prevention (60%):</u>

- Information and services to prevent:
  1. injecting drug transmission (65% of prevention efforts or 25.4% of total efforts);
  2. sexual transmission (25% of prevention efforts or 9.8% of total efforts);
  3. mother-to-child transmission (10% of prevention efforts or 3.9% of total efforts);
  4. at-risk youth will be targeted as a subcategory within the activities aimed at reducing injecting drug use and sexual transmission.

<u>Care & Support for those Affected (22%):</u>

- Expanded psycho-social support and self-help services;
- Family and community care of HIV positive children.

Cross-Cutting Interventions (18%):

- Voluntary Counseling and Testing (VCT) services.

In addition to support for the direct provision of information and services, providers of information and services will also be supported to have a voice in national, regional and local decision making forums. Examples include policy formulation, development of legislation, strategic planning, and programmatic reviews and evaluations. Additionally, building the institutional capacity of governmental, non-governmental and private service providers will be another component of this IR. Selected service providers will develop, as part of a situational analysis process, a detailed capacity assessment that will identify key strengths and weaknesses, and will sharpen the organization's mission. This process, and the process of identifying intended beneficiaries not adequately reached to date, will likely result in the emergence of new providers or new programs which will need to be developed and supported.

Prevention (60%):

Injecting Drug Transmission

There are a number of behavior change approaches to reducing transmission of HIV through injecting drug use. These include providing injecting drug users with a hierarchy of interventions, from the most effective in reducing personal risk to less effective options for less than ideal circumstances. The most effective means of reducing drug-related risk is to end all drug use. If this is not possible, the users should end injecting drug use. If an IDU cannot or will not stop injecting, interventions should be focused on changing risk behaviors such as not sharing equipment and using condoms with all sexual partners.

Rehabilitation of drug addiction can similarly be approached through different means. The GOU, through the MOH, provides detoxification services in medical facilities, though, the quality of those services varies greatly. Recovery programs based on the 12 step approach (such as Narcotics Anonymous) have also been implemented successfully by some civil society associations, and other NGOs have provided self-help groups and support for recovering drug addicts. Through NGOs, information targeted to injecting drug users has also been provided as part of these services.

With injecting drug use accounting for the majority of new HIV infections, USAID seeks to support the expansion of existing information[2] and services to reduce illegal injecting drug use. USAID/Ukraine implementing agencies will cooperate with other donors, NGOs and the GOU that fund activities also targeted at reducing HIV transmission through injecting drug use. In addition, anti-drug campaigns can be supported to increase public awareness on drug abuse, to create a culture against drug use (but not the users) and to generate more support for the provision of information and services to those that need them.

[2] Some material production may benefit from central coordination and development. Under the current USAID program, the HIV/AIDS Alliance created and operated an Information and Documentation Center as the IEC-branch of its work. This center targeted different local and national populations, including policy makers, NGOs, and at-risk populations.

Sexual Transmission

Experience elsewhere has shown that the 'ABC' approach to safer sex is effective. This approach promotes abstinence (A), being faithful to one partner (B), or the use of condoms (C). It must be recognized, though, that the 'ABC' approach was primarily designed for general population, sexually transmitted epidemics. This is not the case in Ukraine. However, it may be possible to adapt and adopt the 'ABC' approach in Ukraine and, additionally, add a fourth element; namely, a 'D' for addressing injecting Drug use. USAID seeks to support the piloting and subsequent expansion of this 'ABCD' approach in Ukraine through partnerships with faith-based organizations, civil society associations, NGOs, the GOU and commercial businesses. Under this IR, USAID also seeks to support an increased demand for and use of condoms. This may include piloting ways to increase access to and acceptability of condoms.

Sexually transmitted infections (STIs) impose an enormous burden of morbidity and mortality in Ukraine indirectly through their role in facilitating the sexual transmission of HIV. USAID may provide limited support to improve STI services and referral mechanisms between STI care providers and HIV services. Improving STI care provides an opportunity to reach high-risk populations, as well as bridge populations, which may not yet have high rates of HIV infection, but represent the next potential wave of infection. In this regard, particular attention will be given to developing STI outreach and behavior change communication (BCC) materials for populations such as transport workers, police, military, sailors, and others identified in the situational analysis as having high-risk behaviors.

Mother-to-Child Transmission

A combination of Voluntary Counseling and Testing (VCT), the correct use of ARV drug therapy and other preventive interventions can significantly reduce the risk of vertical transmission from an HIV-positive mother to her baby. Several donors have been working to prevent mother to child transmission (PMTCT). Previous USAID and other donor support to the Odessa Hospital has helped develop PMTCT models for comprehensive treatment and care including staff training at five wellness centers and 11 primary health care centers in the oblast.

Under this IR, USAID will support the training of health and other social services workers in implementing the new and revised PMTCT protocols in order to increase access to quality health care services by pregnant women. New practices in selected health care and social services facilities will be introduced with such facilities serving as demonstration and training sites for workers from other local facilities. New and revised training modules for incorporation into the MOH continuing education curricula for health workers will be developed.

Care and Support (22%)

Through NGOs and civil society associations, many PLWHA have been provided psychosocial support. Self-help groups, counseling, referrals, and access to information and legal counsel and representation will be important complimentary services to reduce stigma and discrimination under IR 3. A particular group in need of support is children who are HIV positive. Presently, some 10% or more are abandoned and subsequently placed in quarantined institutional care. USAID will support services that promote continued family and community care of HIV positive children.

Cross-Cutting Interventions: Voluntary Counseling and Testing (18%)

Voluntary Counseling and Testing (VCT) is an essential component of an HIV program. People who choose to be counseled and tested change their behavior in ways that lower rates of HIV transmission. In particular, those who test negative tend to adopt protective behaviors to maintain their negative status. Accessible VCT services are also thought to be a factor in reducing HIV stigma and in encouraging community support for those affected. Perhaps most importantly, VCT services can be an essential early entry point to social support services and associated care for those infected with HIV. Finally, the counseling and voluntary testing of pregnant women helps reduce the transmission of HIV from mother to child.

Some 250 medical facilities throughout Ukraine are officially authorized to conduct HIV testing and counseling. Legal and regulatory provisions restrict the availability of HIV testing to "certified" government institutions including AIDS Centers, maternity hospitals, dermatology/venereology dispensaries, narcological facilities and others. ("Prevention of AIDS and Social Protection of the Population law dated March 1998; MOH Decree No. 2026, dated Dec. 18, 1998; MOH Decree No. 129 dated, May 5, 2002). Nongovernmental institutions are not authorized to provide HIV testing services, but may offer pre and post-test counseling.

The quality of pre-test and post-test counseling at these facilities varies widely, however. Several donor agencies have addressed counseling needs at the facility level—usually applying World Health Organization standards. MOH health care providers at central, oblast and regional levels, however, rely on a patchwork of *ad hoc* training and service approaches, with VCT training modules varying from several hours to several weeks in duration. MOH leaders at the central and oblast levels note the absence of an official MOH protocol and *prikaz* setting forth a standardized training and service regime. This has hindered attainment of the goal outlined in Ukraine's national HIV/AIDS strategy.

USAID will support the development and dissemination of protocols and orders designed to ensure widespread adoption of quality VCT services, and to expanding those authorized to provide VCT to include non-governmental facilities under IR 2. USAID will back local-level adoption and implementation of these VCT protocols in selected, high-priority areas. Additionally, USAID will support the mainstreaming and expansion of VCT services into the general health services and activities that help facilitate the introduction of rapid test kits.

IR 2: Improved Enabling Environment (20%)

This IR seeks to improve critical aspects of the enabling environment so essential for the effective delivery of HIV/AIDS information and services. Building the institutional capacity of governmental, non-governmental and private service providers will be another part of this IR. It will strengthen organizational capacity to plan, manage and evaluate interventions. To develop the enabling environment, USAID will support activities which:

- Assess, monitor & evaluate the HIV/AIDS epidemic and available services;
- Develop strategic planning and management, particularly at the local level;
- Improve government policy and policy implementation.

Assessing, Monitoring & Evaluating the HIV/AIDS Epidemic and Available Services

Activities in support of this IR of the strategy will involve data collection to better analyze at-risk and affected populations, environmental constraints, facilitating factors, and key opportunities for developing an effective response. USAID seeks to strengthen routine surveillance as well as to initiate periodic surveys. Given USAID's targeted focus on select high prevalence areas, data collection will be concentrated in these areas.

Very limited research has been conducted on risk populations knowledge, attitudes, and behaviors related to HIV – both those with risky drug use and sexual behaviors as well as bridge populations who form a potential bridge between the currently high prevalence core risk populations (such as IDUs and prostitutes) and the lower prevalence general population. The few studies that exist have often used varied methodologies, which makes comparison across sites, or through time, challenging. Consequently, only a limited, and often anecdotal, understanding of at-risk populations and key obstacles to improved delivery of information and services is known. Furthermore, the few studies conducted have been largely unsuccessful in differentiating risk populations into meaningful subcultures of distinct socio-demographic characteristics, risk behaviors, entry points, and responsiveness to programs, media, and messages.

An essential prerequisite to scaling up programs and improving the effectiveness of outreach efforts is to collect more systematic and thorough baseline and formative data. Routine surveillance of indicators of outcomes and impact needs to be strengthened, in collaboration with national institutions tasked to establish and manage these systems. Repeated measure of key behavioral indicators will allow for a more detailed assessment of epidemic trends, in addition to a more robust evaluation of program activities.

In addition to expanding the understanding of at-risk and affected populations, the development of a comprehensive situational analysis requires an understanding of available services. This analysis should focus on several questions: What services are currently available to risk populations? What is the quality of those services? What is their level of accessibility (in terms of awareness of the services, affordability, and client satisfaction, for example)? What obstacles prevent risk populations and PLWHA from receiving information and services? This perspective will also help identify favourable and needed policies to reduce risk behaviors and improve the quality and effectiveness of prevention and care services.

Developing Strategic Planning and Management

As the HIV/AIDS epidemic matures in Ukraine, it will become increasingly necessary to have frequent interactive forums between partners addressing the HIV/AIDS epidemic, especially at oblast and municipal levels. A mechanism of local coordination, communication, and planning should be established early in the process, (ideally under the umbrella of a multi-sector, public/private HIV/AIDS coalition). These strategic planning forums can be used to sponsor the assessment of present results as well as to explore ways to translate such results into behavior change communication approaches and policy recommendations. Given the many organizations combating the HIV epidemic in Ukraine, it is important that all groups stay well informed of the latest findings and state-of-the-art approaches.

These forums can also be used to develop action plans that may include:

- Prioritizing target populations hard-hit by the epidemic;
- Establishing (micro-) geographical foci within high priority areas; and
- Establishing specific and results-oriented goals for coverage of high-risk populations.

Close cooperation between local authorities, commercial business leaders, law enforcement agencies, and other community groups and organizations is required to ensure efficient prevention approaches and to build a sustainable approach.

The process of strategic planning will help build relationships between these organizations, but after the planning process, formal or informal relationships (related to outreach efforts, referral mechanisms, or the provision of care and support) may be required as well. Thus, there will also need to be a way to share approaches, lessons learned, and emerging best practices.

Informed and motivated leaders may then lead the process of advocacy for successful policy changes, and provide a natural base for further replication to other areas of the country. To address many issues, advocacy will be needed to solicit the active involvement of a wide range of public/private community groups in responding to the epidemic. For example, businessmen who adopt non-discriminatory practices in their work place could be recognized. Religious groups could be recruited to formally provide emotional, spiritual, and social care and support to individuals with HIV/AIDS and their families. Advocacy could also include campaigns based around specific policies.

Improving Government Policy and Policy Implementation

The Government of Ukraine's (GOU) policy regarding HIV/AIDS is generally favorable, as represented in the "Plan of National Response to HIV/AIDS in Ukraine for 2001–2003" which was approved by the Council of Ministers in July 2002. Moreover, efforts have been taken by the GOU to combat HIV/AIDS. In 2001, the GOU established a National Committee, headed by the Vice-Premier of Ukraine, to provide systematic development and coordination of the national plans of specific ministries. The committee is also to control and implement governmental strategies regarding HIV/AIDS. The President declared 2002 as the year for HIV/AIDS. The amount of governmental funding for HIV/AIDS has increased from approximately UAH 1 million in 2000 to UAH 11 million in 2002 and UAH 13.8 million in 2003. Under governmental leadership, Ukraine has been awarded a grant from the GFATM for over $92 million over a five year period.

Despite these laudable efforts, inertia, vested interests, stigma issues, and mistrust of NGOs prevent the GOU from taking an even more aggressive policy stance. The reluctance to deal with provocative topics also extends to the senior levels of most oblast administrations.[3] For example, the National Plan has not been accompanied by official protocols, regulations and orders needed for implementation by local governments and NGOs in several critically important areas, such as voluntary counseling and testing, and the protection of the rights of PLWHA and Prevention of

[3] Popularly elected mayors and other senior municipal officials, whose first responsibility is to their constituents, seem more willing to take on these issues. Many of Ukraine's most progressive approaches to the HIV/AIDS epidemic were developed at the municipal level.

Mother to Child Transmission.[4] Many local leaders, especially at municipal level, are prepared to develop, test, adopt, and promote reforms in these areas and others as part of more far-reaching efforts to contain the epidemic.

Given this landscape, USAID/Ukraine will support the development, dissemination, adoption, and implementation of protocols, regulations and orders (*prikaz*), especially in the high-prevalence geographic areas where program resources will be focused. USAID will seek out municipal and oblast leaders who are willing to adopt innovative, broad-based policies and practices that challenge the inertia and prejudice implicit in some elements of GOU policy and legal codes. While focusing firstly on ensuring implementation of existing policies, there are several other policy, legal and procedural issues that must also be addressed nationally. Examples of policies from the civil and criminal codes which place obstacles in the path of an efficient, comprehensive program directed at high-risk segments of the population include:

- Prohibitions on HIV testing by NGOs or private sector medical practitioners.
- Mandatory registration of drug users, prostitutes and PLWHA.
- Procedural and financial burdens on NGOs (e.g., complicated registration procedures, taxes on fund raising, etc.).

As a result of the above policies, NGOs, which provide many of the services to high-risk populations, can only refer their clients to, at times, distant (geographically and socially) government testing facilities. The deep distrust many drug users and prostitutes bear for these facilities, often based on unpleasant prior experience, diminishes the likelihood that they will follow up on the referral.

Much of the existing negativity results from the status and treatment of drug users and prostitutes as criminals or social deviants. One result is that prostitutes are reluctant to present themselves for HIV or STI diagnosis or treatment for fear of facing legal penalties. Similarly, drug users know that acknowledging a drug problem to a government worker will result in a permanent label in their official records, with profound implications for their personal and professional prospects. Simultaneously, stigma and the threat of criminal penalties contribute to the near invisibility of men who have sex with men (MSM). Hence, virtually nothing is known about the risk behaviors of this hard-to-reach group. NGOs able to respond to the special needs of these vulnerable groups and other marginalized populations are hindered in their ability to organize and raise funds by the daunting registration and tax burdens.

IR3: Reduced Stigma and Discrimination Associated with HIV Infection and AIDS (15%)

People living with HIV/AIDS (PLWHA) face discrimination at the workplace; job loss without recourse to legal protection; harassment by law enforcement, prosecutorial, and judicial authorities;

[4] Medecins Sans Frontieres (MSF) has focused on developing clinical guidelines for PMTCT. MSF has drafted an official MOH protocol for the clinical aspects of vertical transmission, and forwarded it to the MOH. No overall protocol combining the work of AIHA, MSF, and other donors has been developed. Under the USAID HIV/AIDS strategy, the Mission will support the development of a comprehensive protocol and MOH order (or set of protocols/orders) dealing with PMTCT. These documents will combine the elements of various "models" developed by different donors in Odessa and elsewhere in Ukraine.

and social isolation within their communities. Being HIV positive is also strongly associated with being a drug user or a prostitute; therefore segments of the HIV infected population that are not drug users and prostitutes are often stigmatized as if they were. Partners of PLWHA or drug users, who may not be HIV positive or drug users, also can encounter tremendous barriers in seeking care and support. In addition, fear that generates stigma and discrimination is evidence that many people in Ukraine are misinformed about the risk of contracting HIV.

In response to overwhelming stigma and discrimination that adversely affects prevention, care and support efforts, USAID will assist PLWHA, for example through the All Ukrainian Network of People Living with HIV/AIDS, other associations of PLWHA, and other civil society groups (faith-based groups, women's organizations, human rights groups, professional associations, etc.) with technical assistance, and financial and material support to address the issues of stigma and discrimination. Specific results that will be encouraged include:

- Giving voice to those affected by HIV/AIDS;
- Promoting a Supportive Environment through Communication Strategies;
- Protection of the rights of those affected by HIV/AIDS.

Giving Voice to Those Affected by HIV/AIDS

The All-Ukrainian network of PLWHA is a young organization trying to tackle the issue of stigma, in addition to other issues, such as access to anti-retroviral therapy. The organization currently has about 200 members in 17 oblasts and its information and networking service reach approximately 2000 people that are HIV positive. The Network and other associations of PLWHA or those affected by it have been supported to advocate for their interests with the GOU, NGOs, commercial businesses and others. For example, they have been helped to represent PLWHA on planning and steering committees, such as the MOH's working groups on the national plan for HIV/AIDS and the Country Coordinating Mechanism for the Global Fund against AIDS, TB and Malaria. The voice and face that PLWHA can give to the epidemic will be crucial in the years to come, in raising awareness, confronting stigma, and improving access to care, treatment and support.

Promoting a Supportive Environment through Communication Strategies

Through this IR, USAID will also seek to strengthen implementation of communication strategies targeted to local authorities and service providers. For example, local authorities and service providers can be encouraged to become members of HIV working groups that include PLWHA so that they will further understand the issues that PLWHA face.

Protecting the Rights of Those Affected by HIV/AIDS

PLWHA representatives advise that new and revised laws, regulations, and service provision protocols are needed to ensure their legal and human rights to health and social services, as well as to guarantee their rights in the workplace and community and before government authorities. No other group is as well placed to advocate for a more supportive legal environment as those experiencing discrimination. Additionally, there are other groups seeking to care and support those affected who also have first-hand experience of stigma and discrimination.

Under this IR, USAID will continue and expand support for policy, legal and regulatory initiatives favorable to PLWHA. Through the PLWHA community, those affected by HIV/AIDS will be

supported to work with local- level leaders, NGOs, the media, and other parties. The goals are to reduce stigma, and to educate both the public and the PLWHA community regarding PLWHA rights and protections under the law. An emphasis will be given to the adoption and implementation of needed policies and laws in selected high-priority regions of the country. Efforts to protect PLWHA rights will require the participation of authorities from all levels of local administrations (including the police, courts, social service agencies), as well as from local businesses, churches, and civil society.

Lastly, PLWHA, and others affected by the epidemic, may require legal support to guard and promote their rights. Access to legal services has been a barrier, although some *pro bono* services have been provided by legal firms, or they have been made available through NGOs. Under this IR USAID seeks to expand PLWHA's access to legal support services.

ADDRESSING GENDER ISSUES

Issues of gender are integral to this strategy. HIV transmission and infection to date has predominantly been among young males. That is not to say, though, that women have not also been affected, but rather the modes of transmission have differed between the sexes. Men have disproportionately been infected through contaminated needles during injecting drug use. Infection of women has mainly occurred via sexual transmission. Thus, some of the components under this strategy, primarily prevention activities and PMTCT, will by necessity be targeted at different audiences. Other activities, mainly those directed at reducing stigma and discrimination, improving VCT, reforming policy, and assisting vulnerable children, will be targeted equally to both sexes.

MEASURING RESULTS

The strategy includes a monitoring and evaluation plan designed to address the three reporting requirements of Intensive Focus Countries under USAID's Expanded Response Initiative. First is the requirement that USAID/Ukraine report yearly the HIV seroprevalence levels for Ukraine. The second requirement for Intensive Focus countries is that they conduct a behavior change survey every three to five years. Third, Intensive Focus countries are required to report on indicators specific to the HIV strategies and programs that they manage. These requirements correspond with standard, recommended guidelines for comprehensive program evaluation. Selected indicators are summarized below, however, these indicators should be considered preliminary as USAID/Ukraine may refine them further in conjunction with USAID/W Office of HIV/AIDS (OHA).

Critical Assumptions

The success of the strategy discussed in this document is dependent on several conditions and factors beyond USAID's control. For example:

- The GOU will maintain a generally favorable policy and legal environment toward HIV/AIDS;
- Government units at the oblast and municipal levels will welcome and participate constructively in partnership arrangements with non-governmental and private organizations;
- The GOU continues to welcome a substantive USAID role in support of Ukraine's efforts to combat the HIV/AIDS epidemic;
- USAID/Ukraine will receive the resources, including those from USAID/W from the CSH account, it needs to implement this strategy.

Results and Reporting

SPO – Reporting HIV National Seroprevalence

USAID will work with the Government of Ukraine, the Joint United Nations Programme on HIV/AIDS (UNAIDS), the World Health Organization (WHO), and others in improving national surveillance systems to comply with the 2007 deadline for effective annual reporting. As a low prevalence country (around 1 percent), USAID will work particularly to improve reporting on populations who practice high-risk behaviors. This reporting is critical for tracking national impact. USAID/Ukraine's goal is to contribute to keeping HIV sero-prevalence less than 5% in the adult population in Ukraine by 2008. Additionally, USAID/Ukraine aims to slow the rate of transmission amongst those groups most at risk (IDUs and prostitutes) by one-half in the selected oblasts in which its programs are implemented.

The Ukrainian Ministry of Health currently screens blood donors and pregnant women[5] for HIV. Current WHO/UNAIDS recommendations call for the establishment of a sentinel surveillance system to measure HIV in pregnant women at select sites. Moreover, the current Ukrainian application to the Global Fund includes resources for improved surveillance. The validity and reliability of national surveillance data at present (and in the near future) is of little benefit for evaluating HIV/AIDS epidemic trends in Ukraine, or for measuring potential impact of USAID-supported programs. USAID will facilitate the reporting of surveillance data but will not use this data as indicators for the Mission's Special Objective 3: *HIV Transmission Among High Risk Groups Reduced and Impact on Those Affected Lessened.*

SPO- HIV Seroprevalence

- HIV sero-prevalence for 15-24 year olds[6]
- % of HIV-infected infants born to HIV-infected mothers[7]
- HIV sero-prevalence among injecting drug users nationally[7] and in selected oblasts
- HIV sero-prevalence among prostitutes nationally[7] and in selected oblasts

IR – Reporting Behavior Change and Strengthened Organizational Capacity

IR level evaluation emphasizes intermediate (3-5 year) program impacts toward the overall goals and objectives. For the 2003-2008 Ukraine HIV/AIDS strategy, IR level indicators will focus on measures of behavior change in key target populations, and on evidence of strengthened networks and organizational capacity of partners.

[5] Screening of pregnant women is not mandatory but interviews with Ukrainian experts revealed that a high percentage of pregnant women are screened.

[6] USAID/Ukraine, as an Intensive Focus Country, will report on several HIV/AIDS indicators that reflect the overall direction of the epidemic, and are required for broader Agency use (STATE 12958, 1/31/02). These national indicators are also "shared indicators", with other major donors requiring them. While these indicators are beyond the manageable interests of this Strategy, many of the activities supported will contribute to achieving progress that will be measured by these indicators that cover prevention, mother and child prevention, care & support and orphans & vulnerable children.

Measuring Key Behavior Change Indicators

Measuring the adoption of protective behaviors by populations at increased risk of HIV infection, and particularly those individuals with contact among both recognized high risk groups such as injecting drugs users, prostitutes, and men having sex with men as well as the general population (i.e., bridging populations), provides an effective way to monitor trends in the overall epidemic over intermediate time frames.

Key behaviors will be measured using USAID/UNAIDS/UNGASS validated standard indicators measured through behavioral surveillance surveys (BSS) with IDU and prostitute populations at the focused sites of intervention.

USAID/Ukraine plans to use indicators related to condom use for tracking progress towards achieving the adoption of safe sexual behaviors. In cooperation with the GOU and NGOs, USAID will track condom use among at-risk populations and among bridge populations (individuals that have sexual contact with at-risk populations and the general population). Key behaviors will be measured using USAID, UNAIDS, and UNGASS standard indicators. In addition to measuring risky sexual behavior among at-risk populations (especially injecting drug users, prostitutes and youth), USAID/Ukraine and USAID/Washington will work to develop means of measuring changes in risk behavior related to injecting drug use. Measuring risk reduction behavior among drug users is less established than measuring reductions in risky sexual behavior. Among the indicators being considered for monitoring are:

IR Indicators - Risky Sexual Behavior Among High-Risk Populations

- Percentage of condom use at last commercial sex among prostitutes, disaggregated by age and sex; (This figure will be reported both nationally and at the specific sites of USAID focus.)
- Percentage of drug injectors using condoms at last sexual encounter, disaggregated by age and sex; (This figure will be reported both nationally and at the specific sites of USAID focus.)

Measuring Stronger Networks and Greater Capacity of Partner Organizations

An important focus of this strategy is the strengthening of collaboration between governmental, NGO/civil society associations and other Ukrainian groups involved in the response to HIV/AIDS. Collaboration is essential to ensure effective dissemination of lessons learned and best practices, and to improve the overall coverage of prevention, care and support activities for marginalized and vulnerable populations.

Although several donor agencies and institutions have developed various tools to assess organizational competence, there are no validated, standard indicators for stronger networks or organizational development. Several important variables are understood, however, to be essential for this effort. These indicators will be self-assessed by partner NGOs and government organizations as a part of strategic and sustainability planning. An additional qualitative component to IR level evaluation proposed could be a case study examining the impact on policy supported

through this Strategy. For example, a qualitative analysis could be conducted about the effects of the development of model VCT and care of HIV positive children.

IR Indicators – Building Capacity

- % of USAID-supported NGOs and government organizations that collaborate with and provide support to other organizations not supported with USAID funding (in selected oblasts)

This indicator will measure the extent to which the Ukraine HIV/AIDS strategy achieves its objectives of increasing the capacity of NGO and government partners: to serve as technical resources to improve the dissemination of best practices and lessons learned; to strengthen networks throughout the country; and to expand coverage within the selected regions.

Measuring Reduction in Stigma and Discrimination

Stigma is literally a "mark" or "blemish" upon someone. HIV is often negatively viewed, and social attitudes may be damaging to those infected or suspected of being infected. This stigma is sometimes expressed by open discrimination in some areas: people lose their jobs, are rejected by their families, or are refused admission to schools and hospitals. Stigma and discrimination are of concern for two main reasons: 1) because they can make life unbearable for people living with the disease; 2) because they can negatively affect prevention and care efforts.

IR Indicator – Stigma and Discrimination

- % of people expressing accepting attitudes toward PLWHA (in selected oblasts)

This indicator will measure what people are prepared to say they feel or would do when confronted with various situations involving people living with HIV/AIDS.

IR- Measuring Implementation and Coverage

An important measure for the assessment of overall program impact is the level of coverage of USAID-supported program activities relative to the size of target populations within the specific geographic regions targeted for interventions. Specific indicators of coverage are currently under development by USAID/UNAIDS/UNGASS. However, approximate measures of coverage can be calculated by applying estimates of population size versus outreach activities and services delivered. To improve the sense of program benefit, and to increase the strategic approach of implementing partners, annual estimates of program coverage will be required from all USAID-supported implementing agencies. USAID will encourage these agencies to share experiences and lessons learned with other organizations working in overlapping sites. They will also be encouraged and to undertake collaborative strategic planning and population coverage estimations together with these other organizations.

IR Indicator – Coverage

- Percentage of target populations reached.

This indicator will measure the percentage of each targeted population (IDU, prostitutes and MSM) provided with outreach and services, defined by sites of intervention.

In addition, all funded activities under the proposed intermediate results will have specific monitoring indicators to assess the implementation and quality of activities. These would be developed as part of work plans and agreements.

Timetable for Measuring Results

Level	Key Indicators	Interval	Source*
SPO	HIV sero-prevalence for 15-24 year olds[7]	Annual	MOH
	% of HIV-infected infants born to HIV-infected mothers[8]	Annual	MOH
	HIV sero-prevalence among injecting drug users nationally[8] and in selected oblasts	2003, 2008	MOH & Rapid survey
	HIV sero-prevalence among prostitutes nationally[8] and in selected oblasts	2003, 2008	MOH & Rapid survey
IR	% condom use at last commercial sex among prostitutes nationally[8] and in selected oblasts	2003, 2008	SW BSS
	% drug injectors using condoms at last sex nationally[8] and in selected oblasts	2003, 2008	IDU BSS
	% of USAID-supported NGOs and government organizations that collaborate with and provide support to other organizations not supported with USAID funding (in selected oblasts)	Annual	Self-assessment
	% of people expressing accepting attitudes toward PLWHA (in selected oblasts)	2003, 2008	BSS
	% coverage (by target population and site)	Annual	Rapid survey

* MOH=Ministry of Health; SW = sex worker; BSS=behavioral surveillance survey

Additional Results Reporting Requirements[8]

The Office of HIV/AIDS's *Guidance on the New Monitoring and Reporting System Requirements for HIV/AIDS Programs* notes that while missions are expected to report on progress in all five USAID program areas (voluntary counseling & testing, orphans & vulnerable children, home-based

[7] USAID/Ukraine, as an Intensive Focus Country, will report on several HIV/AIDS indicators that reflect the overall direction of the epidemic, and are required for broader Agency use (STATE 12958, 1/31/02). These national indicators are also "shared indicators", with other major donors requiring them. While these indicators are beyond the manageable interests of this Strategy, many of the activities supported will contribute to achieving progress that will be measured by these indicators that cover prevention, mother and child prevention, care & support and orphans & vulnerable children.

care, anti-retroviral therapy and PMTCT), "Missions will only be required to report areas where they support programs. But, whenever appropriate, Missions are encouraged to establish or expand programs in these areas." In anticipation of future requests for this information from other USG sources, USAID/Ukraine will also report on the following indicators:

Prevention

- Intermittent reporting on injecting drug use and sexual risk reduction behaviors among key high-risk subpopulations, disaggregated by age and sex.

Mother and Child HIV Prevention

- % of HIV-infected infants born to HIV-infected mothers
- % of HIV-infected pregnant women receiving a complete course of ARV prophylaxis to reduce the risk of MTCT in accordance with nationally approved guidelines

Care and Support

- Number and percent of persons tested, number and percent receiving pre-test counseling, number and percent receiving post-test counseling
- Annual numbers of PLWHA receiving anti-retroviral therapy, disaggregated by age and sex
- Annual numbers of PLWHA receiving home based care, disaggregated by age and sex

Orphans and Vulnerable Children

- Annual estimated numbers of orphans due to HIV/AIDS, disaggregated by age and sex
- Annual numbers of orphans and vulnerable children receiving care and support, disaggregated by age and sex.

MANAGEMENT PLAN

Adopting the Global Development Alliance Approach

USAID/Ukraine will give priority to implementing partners that adopt an approach similar to the Global Development Alliance. The Global Development Alliance (GDA) is USAID's business model for the 21ST Century -- our commitment to change the way we implement our assistance mandate. These alliances aim to serve as a catalyst to mobilize the ideas, efforts, and resources of the public sector, corporate America and non-governmental organizations in support of shared objectives.

The Global Development Alliance (GDA) is based on the recognition of significant changes in the environment of economic development assistance. No longer are governments, international organizations and multilateral development banks the only assistance donors; nor is Official Development Assistance the only source of funding for international economic development. Rather, over the past 20 years, there have been a growing number of new actors on the scene. Foundations, corporations and even individuals are now providing development assistance financing, while PVOs and NGOs bring other assets to bear on development challenges. As a result, the U.S. Government is not the only, or perhaps even the largest, source of U.S. funding and human resources being applied to the development challenge. Specific goals of a Global Development Alliance are to coordinate for impact, to improve the quality and extent of partnerships with NGOs, to leverage private financing of development assistance, and to enhance policy reform through advocacy.

Collaboration between Partners

Given the relatively scarce USG resources that are available for responding to HIV/AIDS in Ukraine, USAID will require that implementing partners of this Strategy coordinate and collaborate with each other as well as with other organizations active in the National Program. USAID/Ukraine resources are insufficient to support the scaling up and rolling out of needed interventions nation-wide. Collaboration with other partners will assure that all available resources for HIV/AIDS in Ukraine are used efficiently.

Finally, USAID/Ukraine will maintain close communications with GOU, NGOs and other donors, as well as with USAID implementing agencies and implementing organizations supported by the GOU and other donors. USAID will continue to be represented on the Country Coordinating Mechanism for the Global Fund Project and through this strategy will provide technical and programmatic support as appropriate for implementation of the Global Fund project. To date, USAID's assistance to the implementation of the Global Fund project has been crucial. The Global Fund project in Ukraine is a new initiative, and like most new initiatives a number of problems are inevitably associated with the start-up stage. It will be critical for USAID and all of its HIV/AIDS implementing partners to remain engaged in the GFATM. USAID/Ukraine will also encourage the GOU to establish a High Level Working Group on HIV/AIDS and will participate as appropriate.

ANNEX I

RESPONSES TO HIV/AIDS IN UKRAINE AND LESSONS LEARNT

Responses to HIV/AIDS in Ukraine

Response of the Government of Ukraine

The policy and legal environment in Ukraine is generally favorable for combating the spread of HIV/AIDS. A significant gap exists, however, between national level policies and laws, and practices implemented at the local level. The Government of Ukraine (GOU) still treats HIV/AIDS primarily as a medical issue. Prevention activities have been funded mostly by international organizations. Stigma associated with PLWHA remains a large barrier to accessing information and services. The fact that HIV testing is legally limited to government-licensed facilities further hampers the efforts to reach those most at risk, because marginalized populations are unlikely to use government and formal sector services. However, some oblast[8]-level government AIDS centers recognize their inability to reach high-risk populations and have begun collaborating with NGOs.

International Response

USAID's current response to the HIV epidemic in Ukraine is a multi-pronged approach, of which the primary focus is on HIV prevention through NGO capacity building. The major component of this approach is represented by USAID's contribution of $3.47 million (2000–2002) to support the Ukraine program of the International HIV/AIDS Alliance under the terms of a joint United States-European Union agreement. The Alliance currently supports 25 Ukrainian NGOs that work in 20 oblasts. USAID has also supported a small grants program, implemented by the Counterpart Alliance for Partnership, to support capacity building of 11 NGOs involved in HIV/AIDS activities; the POLICY project to strengthen the advocacy skills of NGOs working to defend and promote the reproductive health rights of PLWHA; and a prevention of mother-to-child transmission (PMTCT) demonstration project in Odessa, developed and implemented by the American International Health Alliance in conjunction with Medecins Sans Frontiers.

Several other donors are operating in Ukraine:

- the European Union (under a partnership agreement with USAID) has committed $1.8 million to support HIV prevention work among youth through July 2003;
- the United Nations (UNDP, UNICEF, UNFPA and ILO) has committed approximately $1 million per year for HIV programs in Ukraine;
- The International Renaissance Foundation/Soros is providing between $250,000 to $500,000 annually through December 2003 for its HIV prevention efforts in Ukraine;
- Médecins Sans Frontières (MSF) has committed $1.3 million for a three-year program to work on the development of clinical protocols for reducing mother-to-child HIV transmission; and

[8] Oblast is the equivalent of a state.

- The United States Department of Labor has funded a $1 million, four-year Academy for Educational Development (AED) program to implement an HIV prevention and PLWHA antidiscrimination program in the workplace.

In April 2002, the Global Fund for AIDS, Tuberculosis, and Malaria notified Ukraine that its proposal and first two years of funding ($21 million) had been approved. The proposal is for $92 million over five years. It is important to note, though, that funding for years three to five is dependent on performance during the first two years. The proposal is solely for HIV activities and has four main components:

- **Care, treatment and support for PLWHA (67 percent)**. Expected results:

✓ Providing HIV-infected individuals with access to antiretroviral therapy and treatment of opportunistic infections with the appropriate level of quality assurance of treatment; to increase that figure to 100%
✓ Organizing support for HIV-infected persons with TB
✓ Establishing capacity for providing comprehensive care to HIV-infected children
✓ Expanding the Prevention of Mother-to-Child Transmission program
✓ Developing the system of care and compassion for patients with HIV

- **Information, education, and communication (22 percent).** Expected results:

✓ Reducing the stigma and discrimination against people living with HIV/AIDS
✓ Increasing the use of condoms among young people
✓ Increasing the coverage of adolescents and youth by HIV/AIDS education
✓ Integration of prevention programs into training courses

- **Targeted interventions in high-risk populations (8 percent)**. Expected results:

✓ Implementing programs in four new regions of Ukraine with prevention measures covering not less than 60% of injecting drug users by 2006
✓ Changing IDU behavior in order to increase condom usage with non-regular partners within past week on 40% by 2006
✓ Increasing the proportion of female sex workers using condoms while providing services within the past week on 60% by 2006
✓ Increasing the proportion military men with correct information, attitudes (70%) and practice (60%) towards HIV/AIDS
✓ Increasing the proportion of prisoners with correct information, attitudes and practice regarding HIV/AIDS on 40% by 2005

- **Monitoring and evaluation (3 percent).** This component aims to:

✓ Develop and implementing a system to monitor and assess the Ukrainian HIV/AIDS program in its different components: HIV prevention in general population and vulnerable groups, care and support for HIV/AIDS patients as well as surveillance on epidemic.

The World Bank has been negotiating a major loan with the Ukrainian government since 1998 to support HIV and tuberculosis efforts. The terms and content of the program have been finalized, WB Board approved the loan in December 2002, the GoU has signed the loan, but the Ukrainian

parliament has not yet ratified it. There has historically been reluctance for the Ukrainian parliament to ratify social sector loans, thus, this funding remains unsecured. The loan is for US$ 60 million, with $31 million for HIV/AIDS interventions. The objective of this project is to reduce HIV/AIDS morbidity and mortality through an HIV/AIDS program largely focused on prevention of transmission among high-risk groups. The project, to be implemented over a four-year period, would: (i) provide the government with the means to stabilize the two epidemics; (ii) strengthen Ukraine's capacity to control TB and HIV/AIDS and iii) extend control efforts to prisons. To that effect, the project will help implement cost-effective prevention, diagnosis, treatment and epidemic control strategies, and build institutional capacity by training health personnel and undertaking a systematic program of monitoring and supervision.

Results and Lessons Learned from Assistance to Date

Very few donor-supported HIV/AIDS programs in Ukraine have been in operation for more than five or six years. Given the explosion of the epidemic during that time and the relatively few resources that have gone into responsive programs, expectations of results and impact should be modest. Nevertheless, those programs have laid the foundation for effective action and positioned Ukraine to take advantage of the significantly increased resources now expected. Among the accomplishments of these programs are:

- Numerous energetic and committed Ukrainian NGOs have been established and strengthened in such skills as organizational management, service delivery and community mobilization.

- Ukrainian decision makers and the international community are now seized with the severity of the epidemic and its potential to jeopardize or slow Ukraine's economic, political and social progress.

- Work has progressed at the national level on a range of HIV/AIDS-related laws, policies and protocols.

- A clearer epidemiological and sociological understanding of the epidemic is slowly beginning to emerge

- Pilot programs to prevent maternal to child transmission have been successful and are being replicated.

- Extensive behavior change communication materials for high-risk groups have been produced and substantial demand has been generated for those materials by their target audience.

- Radio campaigns have increased awareness and knowledge about HIV/AIDS.

Perhaps as valuable as the accomplishments themselves have been the lessons learned during the process. Primary among these are:

- It is extremely difficult to reach those at highest risk, but they can be reached. UNAIDS recommends that programs must "cover" approximately 60% of the individuals within such groups if the epidemic is to be brought under control; so far "coverage" in Ukraine is estimated at 10% to 15% of those groups. The approaches and strategies may need to be as diverse as the groups themselves.

- Once "reached," it is even more difficult to bring about behavior change, but behavior can change. Behavior change comes slowly and the messages and incentives being offered need to be continually reinforced.

- NGOs are crucial to reaching vulnerable groups. Programs can be scaled up only if NGO capacities are significantly increased, if new NGOs are established and if those organizations operate more cooperatively and synergistically.

- Geographic- and population-focused approaches are likely to be more effective than broader nationwide efforts.

- Medical aspects of HIV/AIDS are but a fraction of the control equation; overcoming complex social, economic, political, cultural and logistical challenges are even more difficult.

- Peer education is especially effective with youth, IDUs and street children.

- Government at all levels must be active partners in the program.

- Outreach, prevention, and care/support services can be effectively delivered only within supportive environment.

Annex II

HIV and Tuberculosis in Ukraine

Economic and social factors such as poverty, dwindling resources for public health, substance abuse, especially alcohol and injecting drug use have contributed to the substantial increase in tuberculosis cases in Ukraine during the last decade. These same factors have also contributed to the spread of HIV infection. In 2001 an estimated 41,225 people in Ukraine are infected with tuberculosis giving a rate of 84 per 100,000 (Ref 1). In 2002, a confirmed 36,471 people have been notified with tuberculosis giving a rate of 76 per 100,000 (Ref 2). USAID/Ukraine support to tuberculosis to date has mainly focused on the piloting of DOTS in Donetsk oblast. It is hoped that by showing the effectiveness of DOTS in Donetsk, that further acceptance of the program will be forthcoming from the GoU leading to acceptance of the internationally recognized, cost-effective approaches to TB control. In general, though, DOTS implementation has been protracted and progress has been slow. Other TB projects include a DOTS pilot in Kiev implemented by KNCV(funded by the EU) and a DOTS strengthening program to be implemented by PATH and funded through the USAID's Child Survival and Health Grants Program.

There may also be a substantial overlap between populations with active tuberculosis disease, those infected with TB and those at risk for HIV infection, leading to a potential increase in the number of coinfected individuals. The yearly risk of developing active TB for people coinfected with HIV is about 10%, compared with a lifetime risk of 10% for HIV-negative individuals (Ref 3). If the spread of HIV is not prevented, coinfection will accelerate the resurgence of TB. The potential for massive TB spread in HIV-infected individuals in settings such as prisons, in which the rates of TB and multi-drug resistant TB (MDR-TB) are the highest, is especially alarming. The system in Ukraine for diagnosing and treating tuberculosis is like the system for HIV/AIDS in that it is highly verticalized. Little active interaction has taken place to date between these two systems, although in some oblasts such as Donetsk there is a growing recognition for collaborative efforts.

In addition to measures to limit HIV transmission, several other steps can be taken to further limit spread of HIV-related TB in Ukraine. These steps include widespread implementation of DOTS, the development of programs to successfully treat MDR-TB, and the treatment of latent TB infection in persons who are HIV-positive. This last measure has been shown to be highly effective in preventing development of active TB in several settings (Ref 4). HIV testing is done primarily in the government HIV centers while TB diagnosis is done in TB clinics and hospitals. Needed at this stage of the HIV epidemic, given the realities of the Ukrainian medical system, is a TB screening and referral mechanism done through the government AIDS centers. In other words, there needs to be training within the HIV centers to perform a basic TB screening test and the establishment of a referral system to the TB clinics and dispensaries. USAID/Ukraine's HIV/AIDS Prevention Strategy needs to explore ways in which it can further support and export successful models promoted through the TB control program as well.

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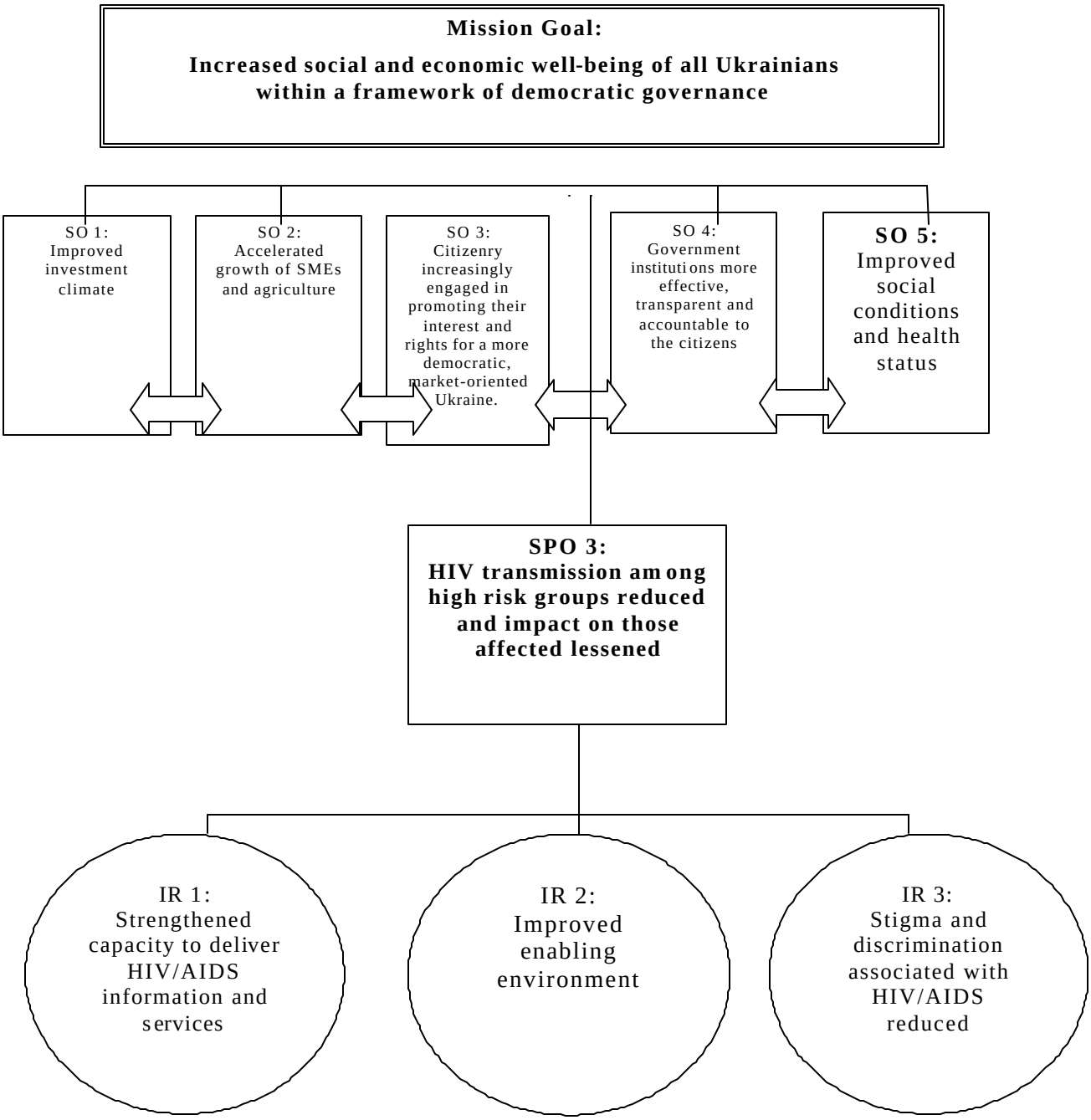
ANNEX III


Mission Goal:
Increased social and economic well-being of all Ukrainians within a framework of democratic governance
SO 1: Improved investment climate
SO 2: Accelerated growth of SMEs and agriculture
SO 3: Citizenry increasingly engaged in promoting their interest and rights for a more democratic, market-oriented Ukraine.
SO 4: Government institutions more effective, transparent and accountable to the citizens
SO 5: Improved social conditions and health status
SPO 3: HIV transmission among high risk groups reduced and impact on those affected lessened
IR 1: Strengthened capacity to deliver HIV/AIDS information and services
IR 2: Improved enabling environment
IR 3: Stigma and discrimination associated with HIV/AIDS reduced

ANNEX IV

USG POLICY FRAMEWORK

USAID/Ukraine will implement this HIV/AIDS Strategy in accordance with applicable law and administration and agency policies. Activities designed to stem the transmission of HIV/AIDS among high risk groups, such as prostitutes and injecting drug users, are clearly needed in light of all the evidence. Such activities and related communications must be managed sensitively. Existing USAID policy, set forth in the Agency's *FY 2003 Guidance on the Definition and Use of the Child Survival and Health Programs Fund*, provides guidance on prevention programs for injecting drug users and the use of funds for population activities. In addition, State cable 267675 (Dec 2002) specifies that organizations advocating prostitution as an employment choice, or which advocate or support the legalization of prostitution, are not appropriate partners in USAID anti-trafficking activities, at any level.

HIV/AIDS Prevention Programs for Injecting Drug Users (IDUs)

USAID is committed to supporting effective strategies to prevent the spread of the HIV/AIDS pandemic by injecting drug users. However, USG policy is not to use federal funds for the purchase or distribution of injection equipment (needles and syringes) for injecting illegal drugs. Therefore, USAID funds may *not* be used to purchase commodities to be used in either a needle/syringe exchange program or research programs on needle/syringe exchange. Many other activities targeting IDU and HIV/AIDS reduction are acceptable in a USAID-funded program. Although USAID implementing agencies may cooperate with other donors and governments that fund those activities not permitted to be funded by USAID, in these cases, the USAID funds must be segregated and coded separately.

Legislative and Policy Prohibitions on Support for Family Planning/Reproductive Health (FP/RH) Activities

Voluntarism and Informed Choice: USAID places the highest priority on ensuring that its FP/RH activities adhere to the principles of *voluntarism* and *informed choice*. The Agency considers an individual's decision to use a specific method of family planning, or to use any method of family planning at all, *voluntary* if it is based upon the exercise of free choice and is not influenced by any special inducements or any element of force, fraud, deceit, duress, or other forms of coercion or misrepresentation. USAID defines *informed choice* to include effective access to information on family planning choices and to the counseling, services, and supplies needed to help individuals choose to obtain or decline services, to seek, obtain, and follow up on a referral, or simply to consider the matter further.

Tiahrt Amendment: Child Survival and Health (CSH) voluntarism requirement: USAID-assisted family planning projects supported with CSH funds must meet certain standards of voluntarism.

Helms Amendment (section 518 of the FY2003 foreign operations appropriations act, and similar sections in other years' acts): USAID funds may not be used to pay for the performance of abortion as a method of family planning or to motivate or coerce any person to practice abortions.

Mexico City Policy: This policy prohibits non-U.S., non-governmental organizations to which USAID provides population assistance funding, either directly or through sub-awards, from using their own or other, non-USAID donor funds to provide or actively promote abortion as a method of

family planning. The policy is described in more detail in Contract Information Bulletin 01-08 (revised).

Other Legal and Policy Considerations

Protection of Human Subjects: Part 225 of title 22 of the Code of Federal Regulations states rules on research involving human subjects. As defined in the regulation, "research means a systematic investigation, including research development, testing and evaluation, designed to develop or contribute to generalizable knowledge. Activities which meet this definition constitute research for purposes of this policy, whether or not they are conducted or supported under a program which is considered research for other purposes. For example, some demonstration and service programs may include research activities." See also the Agency documents titled "Procedures for Protection of Human Subjects in Research Supported by USAID" and "USAID Research: Policy Framework, Principles and Operational Guidance".

Breastfeeding: ADS chapter 212 states policy on "breastfeeding programming as related to mother-to-child-transmission (MTCT) of HIV/AIDS." USAID promotes optimal breastfeeding in programs that include MTCT, especially those that include voluntary counseling and testing (VCT), or offer counseling that includes other feeding options.

Contraceptives: ADS section 312.5.3d states policy on procurement of contraceptive products. Among other things, it states that "all condoms provided for HIV/AIDS programs shall also be procured under the centrally managed contraceptives contracts."

Police and Military restrictions (sections of the Foreign Assistance Act of 1961, as amended): There are statutory prohibitions on use of USAID funds to assist law enforcement and military entities and their personnel. However, under certain limited circumstances it is possible to fund HIV/AIDS activities that assist, in part, individuals in law enforcement and the military.